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Perspective from Two Professions: Two professionals Making Meaning of the Clinical Educator Role

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Perspective from Two Professions: Two Professionals Making Meaning of the Clinical Educator Role

by

Tara Payor

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy
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DEDICATION

For my children, Harlow and Hendrix. You are my greatest teachers. The experiences we share are some of life’s greatest pleasures. May the meanings we make from our shared experiences enrich our lives until forever. Because of you, for you, I work to be a better person—every day. While the content of this dissertation might not interest you or help propel any of your interests forward, I hope my journey to get here does. I am anchored by hope that I can teach you how you are so much more powerful and resilient than you know.
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I am at this place in life because I am supported by others. Without my husband, Austin, it is unlikely this study would have come to be. It is through his pursuit of doctoring that I gained a certain interest in and access to medical education. As someone who has worked through rigorous academic programs in order to professionally practice his passion, he has always understood how much my work means to me. While we connect with one another on so many levels, our intellectual dimensions and pursuits add another power line to our relationship. He understands that my professional identity is deeply tied to all parts of who I am, and he has respected and encouraged that as I have worked through this process. We have leaned into one another in order to achieve our professional goals and, without that support, I don’t know where the entirety of our lives would be. Thank you.

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ABSTRACT

The purpose of this phenomenological study was to describe how professional educators make sense of their role in helping novice practitioners make meaning from authentic clinical practice. Simultaneously studying a clinical educator from teacher and graduate medical education, and subsequently setting their stories side by side, speaks to the interest both professions have in learning from the other. Both clinical educators were Board certified in their respective area of practice. In-depth phenomenological interviewing was used as the study’s methodology, and the professional formation construct served as the study’s conceptual framework. Data corroborate findings in the literature that there is a lack of consensus about what the clinical educator role entails. Participants showed alignment with the professional formation conceptual framework and demonstrated that the clinical educator role is multifaceted, complex, and made up of more than discrete functions. Their capacity to support professional formation comes from their ownership of a special mix of cognitive and behavioral processes, professional knowledge, and personal attributes. Given both professions’ interest in and ongoing efforts to improve clinical education, the study can help both continue their work toward understanding the clinical educator role and ensuring that people selected for the role are chosen through thoughtful methods and provided with clinical-educator-specific professional development throughout the professional lifespan.
CHAPTER ONE: INTRODUCTION

Watch your thoughts; they become words.
Watch your words; they become actions.
Watch your actions; they become habits.
Watch your habits; they become your character. Watch your character; it becomes your destiny.
–Frank Outlaw

Introduction to the Study

Winding through canopy roads, he attempted to entertain me with first dinner date banter. He wanted to go to medical school—aspired to be a doctor. Was I supposed to swoon? Through thoughtful questioning, I resisted. Perhaps that was the educator bubbling within me. *What are your grades like? Do you know how competitive the medical school application process is? You have an active social life. Are you disciplined enough to study medicine? To do medicine? What about your extra-curriculars?* I learned he appreciated my inquisitive nature. He told his family, his treasured grandma Henrietta, I kept him on his toes. That January night, unbeknownst to me, I joined him on the journey to doctoring. During that last stretch of the undergraduate experience, we began missing out on a certain degree of carefree-emerging-adulthood (Arnett, 2000). Sundays spent at MCAT prep courses. Late nights studying at a smattering of libraries—finding ways to keep a disciplined life a little fresh. I did some phenomenal writing back then. A honeymoon delayed because the MCAT took precedence. It’s as if medicine has always enacted the role of mistress. Medical school meant lectures, and lectures, tests, and more traditional tests. It meant leaving the familiar to learn how to practice the practice in rural and urban places. It meant month long audition rotations away from home. Residency brought a loneliness I hope not
many ever have to get to know. Loads of clinical practice can weigh heavy on a wife and daughter’s soul.

As his professional life developed, mine did too. I taught, I learned, I went back to school. I questioned, I wrote, I worked hard to develop and refine my own professional practice. I practiced. I went back to school. And, it was then, during doctoral coursework, while reading reports, calls, briefs, Shulman, Schon, Grossman, and Ball, I realized how intertwined our professional lives had become. Thirteen years of paving and weaving, together. Doctoral studies helped give me a language to better articulate hunches and questions I felt and pondered all along. An insider to some aspects of medical education, and simultaneously an outsider to many others, I felt at times energized and at times frustrated as I read reference after reference to medical education in the teacher education literature. I remember cohort members and professors sometimes looking to me to fill in certain gaps and attempt to clarify certain assumptions about the long, clinically rich journey to doctoring.

The interconnectedness of particular aspects of my personal and professional lives made me question what I read about medical education within the teacher education literature. Particularly, my outsider experience of medical education, as the significant other of an insider to the process, from meeting requirements for entry into UME through completion of GME, made me acutely aware of some of the weaknesses in the extensive medical education process seemingly left out of the teacher education literature. The literature didn’t delve into physician burn out (i.e. as related to high numbers of duty hours, which don’t account for other professional responsibilities residents are required to meet); it didn’t address maladaptive resident-physician behaviors (e.g. alcohol and drug abuse), as related to their extensive hours in the clinical practice setting; it didn’t explain resident-physician suicide and it’s potential
correlation to 80-plus-hour-work-weeks, which can leave some residents feeling like work subsumes many other facets of life. As a teacher educator, my understanding of the need for revision of the clinical practice experiences, as predominantly structured for preservice teachers, broadened and deepened. My lived experience as a university based practicum instructor enabled me to understand some of the conceptual and structural fault lines in clinical practice. My role as a university supervisor to student teachers completing the final internship positioned me between two teacher education contexts, the college of education and the 6-12 school environment, and allowed me to understand—through my own sort of experiential learning—why the US has been written off as a “disenfranchised outsider” (Slick, 1998). Admittedly, prior to fully immersing myself in the medical education literature, I carried certain assumptions about clinical education at both the undergraduate and graduate medical education levels. My intrinsic bent toward inquiry, further nurtured by doctoral work, steered me toward the medical education scholarship, medical education blogs, and ongoing work being carried out by organizations with a vested interest in medical education (e.g. Josiah Macy Jr. Foundation; American Medical Association). I understood that teacher education scholarship and reform efforts calling attention to medical education, without deep grounding in an understanding of it, would do little in contributing to systematic, sustainable changes in how particular features of preservice teachers’ clinical experiences are enacted. Acknowledging that my status as a doctoral candidate does not put me in a position of power to make large scale change in teacher education, I remain anchored by my inquiry stance (Cochran-Smith & Lytle, 1999) and its concomitant characteristic that, as a professional educator committed to improving my practice for the benefit of P-12 students’ and student-teachers’ learning, I systematically study particular teaching and learning issues so that appropriate, informed professional action can be taken.
I believe, based on professional lived experiences each in a number of roles and aimed at a number of different ends, that medical and teacher education—as professions intentioned on improving particular conditions for human beings—stand to learn from one another. With specific regard to enacting the most educative clinical practice experiences so that productive habits of mind and action are cultivated and nurtured in novices, habits extending into independent, professional practice, neither medical nor teacher education has it all figured out. Considering how the two fields can come together and learn from one another, I align myself with Cooke, Irby, and O’Brien’s (2010) stance that “The fundamental goal of medical education is professional formation, the hallmark of which is commitment to making things better for patients and, more broadly, the public—an aspiration to excellence across the domains of practice” (p. 38). Aligned with figures like Feiman-Nemser (2001a) and Cooke, Irby, and O’Brien, The Holmes Group (1986) long ago recognized the importance of creating preservice preparation and professional development programs that nurture learning across the professional lifespan and promote field building by practitioners. As I see it, teacher education is charged with preparing preservice teachers to enter professional practice with the dispositions, habits, and orientations that will help them remain steadfast in their commitment to “make things better” for students and, flowing from those improvements, society.

**Background of the Study**

**Some History of Medical Education**

Medical education, as we know it today, has its roots deeply planted in Abraham Flexner’s (1910) seminal report. Flexnerian medical education consists of two years of traditional science instruction followed by two years of clinical practice. These are features of what has come be known as undergraduate medical education (UME). Occurring after four years
of baccalaureate studies and followed by additional years of residency training (i.e. graduate medical education), Cooke, Irby, & O’Brien (2010) explain the purpose of UME as follows: “[T]o accomplish the general professional education of the physician and to ready physicians-in-training for supervised practice during residency training” (p. 19). During the last two years of medical school, students engage in clerkships. Serving as practica, clerkships allow students to apply and further develop their foundational medical knowledge in medicine’s central specialties (Cooke, Irby, & O’Brien). Clerkships are rooted in Flexner’s model, and third year clerkships in particular remain a staple of UME.

There is a move among medical educators to decrease the number of years student doctors are required to spend in the medical school classroom and subsequent residency training. Such calls account for the varying paces at which individual learners can successfully move through curriculum and myriad clinical practice experiences (American Medical Association, 2007a). I believe a valid case can be made for the stance that medical education, as traditionally structured, may take too long. Shulman (2005), a former medical educator, has identified the absence of and made a case for a signature pedagogy in teacher education. But, the present standardization in medical education, rooted in Flexner’s work, may contribute to unnecessarily long professional education. Accounting for both UME and GME, medical students can expect to spend a minimum of seven years in training before entering independent practice. Cooke, Irby, and O’Brien (2010) argue that if undergraduate and graduate medical education were more individualized (i.e. competency rather than time based) the length of training, and the resulting debt, might be lessened. With a certain physician shortage, it’s essential that medical educators work to reform the length of medical education, in ways not compromising physicians’ knowledge development and readiness for practice, because college students with the potential
for developing into exemplary practitioners may choose a professional path that is less extensive and less costly.

Flexner, influential in providing each needed structure and extensions to medical education, realized there was more to UME than memorizing scientific facts and principles. He understood the importance of clinical practice experiences that provided student doctors opportunities for further developing, refining, and applying their scientific knowledge. But, like groups of medical educators today, Flexner knew that scientific knowledge was not constant and could not be approached as such. Through inquiry and innovation what is considered scientific, factual knowledge today—and taught in the medical school classroom—might change, albeit in a potentially nuanced way, tomorrow. Since Flexner’s time, scaffolding learning experiences (i.e. the flow from medical school curriculum to clinical practice experiences), with the understanding that knowledge is evolving, progressive, and situated, has been a struggle in medical education (Cooke, Irby, & O’Brien, 2010). Bok (2013) acknowledges that medical schools have been effective at keeping up with changes in the sciences and arming students with the technical skills needed for clinical practice. But, medical-school-classroom and clinical experiences have not been woven together and enacted in ways effective toward helping novices grow into field-building practitioners (Cooke, Irby, & O’Brien) who are in touch with the humanistic parts of their profession. When medical-school-classroom curricula and clinical practice experiences aren’t intentionally woven together students have been found to perceive the clinical practice opportunities as unimportant (Yardley, Brosnan, & Richardson, 2013). Bok (2013) notes that medical education’s fractured organization and delivery have been problematic. Without clear reciprocity between the medical school and the clinical practice context, students’ attention commonly turns to acquisition of factual knowledge and assessments of that knowledge
instead of turning to how learned factual knowledge has relevance in the clinical practice setting (i.e. for patient care) and has potential for further development (Cooke, Irby, & O’Brien). As Dewey (1904) pointed out in his well-known “The Relation of Theory to Practice in Education,” it’s essential that those preparing novices to fully assume the professional role point novices’ attention in the right direction. Meaning, novices should not view the acquisition of vast amounts of knowledge, passing assessment scores, and the successful completion of both professional school coursework and clinical practice experiences as an endpoint in their professional development (Feiman-Nemser, 2001a). Their attention should be focused on how to further build on learning throughout the professional lifespan.

It serves mentioning how, despite areas for improvement in the undergraduate medical education process, the AMA (2007b) acknowledges that “clinical and academic partners” are making concerted efforts to bridge their work (p. 1). Cooke, Irby, and O’Brien (2010) explain, “Pedagogies that facilitate a situated, participatory learning process closely connected to patient care are the ideal for medical education at all levels. However, if goals such as scoring well on an exam….overtake patient-care goals, pedagogies can reflect a similar shift” (p. 91). Looking forward, efforts aimed at improving medical education must include an understanding of the importance of situating learning in the clinical practice setting. As presently structured, there is a “binge and purge” model of learning that is not productive because students are taking in immense amounts of factual knowledge divorced from the clinical practice context (Cooke, Irby, & O’Brien, p. 112). Holding relevance to the present study, Cooke, Irby, and O’Brien’s vision for medical education includes the following belief: “To the greatest extent possible, learners should approach curricular material, including the sciences foundational to medicine, through questions arising out of clinical work; this is as important for residents as it is for early medical
students” (p. 214). They hold that a restructuring of undergraduate medical education, with clinical experiences beginning early on and driving the learning process, must occur.

**Graduate Medical Education**

Flowing from the model of UME championed by Flexner, Graduate Medical Education (GME) became a cornerstone of medical education more than sixty years ago. Thibault (2011) defines GME as “the portion of physician training between medical school and practice, and is what largely determines the number, specialty mix, and skill of the physicians entering practice in the United States” (p. 5). This period of time, as explained by Johns (2011), beyond including advanced academic and clinical work, “shapes physician behaviors, attitudes, and values” (p. 9). Looking at the Flexner Report today, one might be surprised to find no discussion of GME’s contributions to the medical education process. But, as Whitcomb (2011) points out, when the Report was written, “no organized approach existed…for providing medical school graduates with advanced clinical training” (p. 172). Still, Flexner predicted that a need for serious clinical training after the medical school years would develop because medical school training would not be sufficient for physicians to enter professional practice armed with the knowledge and skills required to proficiently practice medicine. Whitcomb explains that in the early years of graduate medical education interns had little “direct supervision” (p. 182). There was no coherent approach for preparing physicians to practice a particular specialty and interns primarily cared for poor patient populations in small hospital settings. Through the former apprenticeship model, young physicians were groomed for practice through the particular “knowledge and practices of particular senior physicians and hospitals” (Johns, p. 9).

Since the 1950s, professional associations, blue ribbon panels, and others have called for reforms in GME. And, despite the fact that GME has developed into a vast system “with
complex governance and a large amount of public financing” (Johns, 2011, p. 5), important work remains to be done in revising and further developing it. That undergraduate and graduate medical education have developed apart from one another is documented within the medical education community (American Medical Association, 2007; Bok, 2013). Tracing GME’s history, Thibault (2011) points out that medical schools, dating back to the 1920s, didn’t want to play an active role in GME. It is unfortunate that, as Whitcomb (2011) points out, recent studies show residents are completing GME “without being adequately prepared to care for patients of the type that are commonly seen in the practice of their specialty” (p. 209). Despite such evidence, GME has failed to make substantial changes in its structure and enactment.

**Medicine’s Clinical Education**

Though Flexner postulated that a system for education beyond medical school would be necessary, it was not organized for years to come and began as a “loosely structured apprenticeship system” (Johns, 2011, p. 5). Although the clinical practice components of medical education, particularly the residency years, are looked upon as models to follow, looking back, they are somewhat young developments in one of the oldest upper professions. It is encouraging to see how far UME and GME have progressed in a relatively short amount of time. Authentic clinical practice in medical education begins at the undergraduate level and extends through graduate medical education.

Some outsiders may have the perception that medical education has perfected the enactment of a clinically rich professional education process, but the perception is not entirely accurate. Experiential learning has not been the favored approach to help medical students develop deep understanding of the bodies of knowledge and reasoning skills needed for practice. Traditionally, medical education has focused on ensuring students have, first and foremost, a
strong grasp of factual knowledge gained through lectures and readings in the medical school. Present reform efforts, however, support a move toward leveling out the pedagogical methods used to help novices develop their medical knowledge and reasoning (American Medical Association, 2007; Cooke, Irby, & O’Brien, 2010). Drawing on the work of Ericsson (1996), who has written extensively about the importance of “deliberate practice,” Cooke, Irby, and O’Brien note the important role that thoughtfully placed clinical practice activities, coupled with “focused feedback” (p. 49), play in novices’ learning and development. The learning experiences afforded to novices cannot be structured in a happenstance manner and must place novices alongside exemplary practitioners who are committed to helping learners develop the knowledge and habits of each mind and action needed for exemplary professional practice.

It is documented in both professions’ literature that the act of placing novices in the professional practice context does not, on its own, strengthen novices’ learning and development (Yardley, Brosnan, Richardson, 2013; Zeichner & Bier, 2012). Poorly planned clinical experiences can be detrimental by, for example, underscoring preexisting stereotypes. Some rotations have little “educational value” because too much time is spent on administrative tasks and/or educative interactions with more knowing others are absent (Dolmans, Wolfhagen, Essed, Scherpbier, & Van Der Vleuten, 2001, p. 471). Though some of the administrative tasks novices are expected to complete during a particular rotation might be part of their future professional responsibilities, it is important that these activities not be done in isolation from more knowing others or be handed off to residents as a way for the clinically based professional educator to focus his/her energy on other tasks. Novices need to learn how each professional responsibility informs other parts of practice and they cannot be expected to make all connections on their own.

Clerkships remain a standard way to give medical students clinical practice, and they are marked
by a number of challenges. For example, they occur during the last half of UME. Additionally, medical education faculty find themselves unable work closely with student doctors while meeting research and other teaching demands (Cooke, Irby, & O’Brien, 2010).

Another way both undergraduate and graduate medical students are able to engage in experiential learning is through the use of clinical skills centers/simulation labs. However, effective teaching and learning methods are not always observed. Dent (2001) points to the sometimes-apparent lack of coherence between what students learn in coursework and what they experience in a clinical skills/simulation center. Absent each intentional and made-explicit-reciprocit, occasions for productive, meaningful teaching and learning, physically situated in a clinical skills/simulation center, are compromised. Further, educators do not always have formal preparation in “clinical teaching methods” (Catto, 2000, p. 483, as ctd. in Dent). If a medical educator uses lecture as the predominant instructional method, and continues doing so in a skills/simulation lab, s/he is unlikely to positively impact student learning by capitalizing on methods more effective when teaching and learning are situated in the laboratory setting. Cooke, Irby, and O’Brien (2010) found that teaching in the clinical practice context was seldom characterized by “sequencing, continuity, and guided support along a developmental trajectory” (p. 96). If experiential learning and authentic clinical practice experiences are to serve as occasions for advancing novices’ “workplace learning” (p. 96), reciprocity between professional school based and clinical practice educators must increase. When designing novices’ learning experiences is a concerted effort, the conceptual and structural coherence created can help both educators and novices make necessary connections between contexts and enable both groups of faculty to better guide novice practitioners along their individual, professional development trajectory.
Worth underscoring is the point that, despite the meaningful learning they can help set in motion, clinical practice experiences do not serve as a cure-all instructional method for professional education. Learning in the professional practice context has sometimes been characterized by novices’ proficiency development in procedural activities without developing undergirding knowledge structures about why particular procedures exist and when they should be enacted (Cooke, Irby, & O’Brien, 2010). If clinical practice experiences fail to support broad and deep conceptual understandings, learners are likely to enter professional practice unable to adapt to ever-changing conditions and unanticipated events. When medical students move on to residency, the program’s “extensive and intensive” clinical experiences should be structured so that residents’ specialty specific knowledge and repertoire deepen, develop, and become increasingly intertwined (p. 21). Currently, however, residency is not always marked by the sort of clinical education experiences that help novices acquire, understand, and enact the habits needed for practitioners to affect change for the profession and society (Bok, 2013). The most effective clinical practice experiences will help novice practitioners develop the capacity to demonstrate flexibility in cognitive and practical actions.

Some of the present work aimed at improving medicine’s clinical education includes attention to Miller’s (1990) Pyramid of Clinical Competence. The Accreditation Council for Graduate Medical Education (ACGME) (2012) drew from Miller’s Pyramid when creating the six domains of clinical competencies. Miller’s model progresses in the following way: knows; knows how; shows how/shows can do; and, does. At early stages of residency training, learners are assessed through more traditional examinations. As learners gain knowledge and clinical competence, they are more regularly observed enacting particular clinical tasks and assessed through the use of standardized patients and simulation. Conceptually cutting through present
efforts to improve clinical practice experiences is a view of clinical education along a continuum that extends through the professional lifespan. In this view, clinical education, or “clinical professional development” (Nasca, 2012), does not end once novice practitioners demonstrate they can “do.” By the end of graduate medical education, though, residents should proficiently enact the multidimensional professional role (Nasca).

As a result of their extensive fieldwork, Cooke, Irby, and O’Brien (2010) identified two areas needing reform in GME: (1) the preparation of and professional development opportunities offered to faculty, and (2) assessment methods. Regarding the first area, it is important to understand clinical education as a dynamic and complex activity. Throughout their work, the authors observed discussions about teaching and learning that made the process seem more simple and direct than it is. That said, educators must be given time to further develop their teaching skills through activities like structured professional development opportunities, observations, and feedback. These activities cannot happen if clinical education is not valued and not given the necessary financial support. The authors note that “financial pressures” are weakening clinical education because teaching and learning are being pushed to the periphery (p. 7). Citing the 1998 Dearing Report, Dent (2001) notes that there are shifting attitudes about the importance of formal “training in teaching techniques” and the need for an “awareness of contemporary educational theory” (p. 484). It remains unclear, however, how such training and awareness ought to be provided and garnered. In its ongoing work to improve clinical education models, the Josiah Macy Jr. Foundation (2014) recognizes that “practical and logistical hurdles” (p. 2) must be surmounted in order to offer faculty professional development aligned with today’s medical education needs.
Though medical education might be viewed as clinically rich, clinical educators don’t enjoy any level of prestige for their work. Rather, despite a particular faculty member’s genuine interest in fieldwork, s/he is required to heavily focus on research, publication, and generating grant dollars. Harden and Crosby (2000) acknowledge a need to elevate the status of teaching within the medical community and work toward a view of teaching as engaged practice, which differs from assuming “a cookbook of recipes” is enough to inform pedagogical practice (p. 561). The AMA’s (2007b) present efforts to reform medical education include an understanding that faculty promotion and tenure guidelines should account for involvement in each planning for and enacting medical education. Articulating a rationale for their reform oriented work, the AMA writes the following:

There is a universal call to transform the practice and teaching of medicine…. Improving physician education across the continuum requires an educational system that sustains leaders who encourage creativity and change, teachers who are empowered to play a critically important role in the academic health center and members of organizations…who promote and are rewarded for change (p. 1).

Thibault (2011) cites the “process by which medical school graduates are trained for independent practice” (i.e. GME) as a critical component in achieving the sort of healthcare system that best serves today’s growing and changing public (p. 23). As presently structured, residency training lacks an integrated approach and is marked by a high number of hours in the clinical practice setting with too few hours for reflection and professional development activities. Cooke, Irby, and O’Brien (2010) believe that the way residents’ days are structured may actually be “inimical to learning” (p. 29). In its “Initiative to Transform Medical Education” the AMA (2007a) states, “Physicians are not prepared to develop and carry out their own lifelong learning curriculum” (p. 11). Carter & Meyer (2013) point out the importance of teaching novice practitioners to each self-assess, play an active role in their own learning experiences, and guide
their own professional development. The AMA notes the importance of creating tools that can be used across the professional lifespan so that learners are better able to “identify their own learning needs” (p. 11). Those charged with structuring residents’ work hours must understand that learning from experience (e.g. particular patient/resident-doctor interactions) does not happen simply because one has lived through the experience and/or because passing time invokes wisdom (Dewey, 1904; Shulman, 1987). Clinical practice in GME stands in need of reform and structural features should be revised in ways accounting for the time novice practitioners need if they are to engage in more intellectual aspects of physicians’ work. Dolmans et al. (2001) believe those planning for and enacting clinical experiences should create more time for novices to reflect “on experiences and…[provide] effective supervision in clinical practice to improve the effectiveness of participating in rotations” (p. 474). If an inordinate amount of hours are spent on direct patient care, it’s unlikely novices will be able to make the time for important intellectual undertakings like reflecting on practice with attending faculty, systematically studying self-identified problems of practice, and sharing findings with other members of their community of practice (Lave & Wenger, 1991.).

Some History of Teacher Education

The path to becoming a teacher, like the one to becoming a physician, has seen a number of significant changes since teachers began receiving any sort of preparation for their role. Though there are alternative certification programs presently contributing to different pathways into teaching, in the 19th century, teachers did not need more than the modern day equivalent of an eighth grade education and to demonstrate they were of good moral standing (“History of Teacher Education,” 2010). It wasn’t until 1867, near the time extended clinical training was taking shape in medical education, that a teaching certificate appeared. Like the apprenticeship
model characteristic of medical education before Flexner’s report (1910), teacher education was also achieved through apprenticeships. As such, a craft view of knowledge was privileged and novices aimed to practice like the practitioner under whom they studied ("History of Teacher Education"). Not until the end of the 19th century did teachers, at that time prepared in Normal Schools, need at least a high school education. Similar to teacher education today, teacher education in normal schools occurred over a period of two years. Preparation in normal schools gave candidates the opportunity to engage in some practice teaching. Eventually, normal schools became teacher’s colleges and teacher preparation included myriad specialized degrees. Around 1970, teacher education became housed in universities. Once the transition from teacher’s colleges into universities took place, teacher education included work in liberal arts, discipline specific coursework, general pedagogy, and experience in the professional practice context ("History of Teacher Education"). It was not until the 1970s, more than 100 years after teaching certificates emerged, that certification standards came to be ("History of Teacher Education"). During that decade, too, research into teaching was predominantly quantitative, experimental, and intent on identifying effective pedagogical methods ("History of Teacher Education"). Also going on were discussions about questions still swirling today. For example, is teaching actually a profession? Though a rationale is provided for why he could not include every profession, Bok’s (2013) text on higher education omits teaching as a profession and focuses on medicine, law, and business. One difference, and area of ongoing debate, between teaching and professions like medicine and law is teaching’s lack of a codified body of knowledge. An accepted and shared body of knowledge, shared with novices through a signature pedagogy (Shulman, 2005), is characteristic of upper professions like medicine and law. The Holmes Group (1986) acknowledged that despite great technological advancements, differences in our society since the
19th century, and changes in student populations (e.g. students with special needs in “mainstream” classrooms), teachers, for the most part, remained “working with the same job descriptions [they] had in the mid-1800s” (p. 6). Though the list of expectations placed on classroom teachers lengthens, their preparation for the role and the resources they have at their disposal fail to develop concurrently. Though teacher education has undoubtedly made progress since its beginnings, debates with implications for how novices are prepared for professional practice continue. As in medical education, affecting sustainable change in a system so large and with so many players (e.g. school districts, state boards of education) can be difficult.

**Teaching’s Clinical Education**

Though student teachers often cite clinical practice experiences as the most important and influential aspect of their preservice education, there are no well-defined answers as to why. In a report commissioned by the US Department of Education, Wilson, Floden, and Ferrini-Mundy (2001) set out to summarize present research on teacher education. Specific to clinical practice experiences, the authors asked, “What kinds, timing, and amount of clinical training best equip prospective teachers for classroom practice?” (p. ii). Despite their across-study-finding that clinical experiences were deemed the most powerful component of teacher preparation, the lack of uniformity in how experiences are sequenced and enacted makes it difficult to study exactly why and how they are such a powerful component. While the field stands to benefit from more large-scale inquiries into how and why clinical practice experiences are repeatedly cited as such a significant component of teacher education, persistent problems with clinical practice are well documented. For example, the problematic practice of using graduate students as teacher educators and student-teacher supervisors is well known (Grossman; Lampert, 2010). The ongoing issues with faculty members’ tenure and promotion guidelines and the devaluing of
work with P-12 schools are also widely known (Grossman; Lampert). Presently, there is a lack of empirical evidence to support claims made about clinical practice experiences. For instance, Grossman, Hammerness, McDonald, and Ronfeldt (2008) note that a number of the factors believed as supporting coherence are actually assumptions unsupported by empirical evidence (e.g. the number of supervisory visits). Speaking to the importance of coherence in a weak professional education process, the Holmes Group (1986) made mention of clinical practice experiences as a portion of preparation when “formal knowledge must…guide…practical action” (p. 51). It follows that Darling-Hammond, Hammerness, Grossman, Rust, and Shulman (2005) have written that teacher education needs to be concerned with more than the “what.” Detrimental to progress in clinical practice experiences, much attention has been given to “what” features of the experiences rather than focusing on how and why. To illustrate, logistic type features of clinical practice (e.g. how many hours student teachers should spend in the field) have received a great deal of focus. It is more important we better understand why time in the professional practice context is productive toward preparing preservice teachers for independent professional practice and how (a) the people associated with and (b) particular features of the experiences can help support preservice teacher learning and development.

Clinical practice experiences have received attention in the teacher education literature for many years. The Holmes Group (1986) brought attention to “ample evidence that if intending teachers do not have carefully supervised and extensive practical experience at the beginning of their careers, most will not learn to teach well” (pg. 10-11). To be clear, their characterization of teaching well does not consist of a bag of tricks approach to pedagogy. Rather, it includes pedagogy predicated on deep understanding of varying, relevant bodies of knowledge and how to help students both think independently and press through difficult intellectual tasks. Over two
decades ago, the Group pledged itself to making clinical practice experiences about more than “exposing prospective teachers to experienced teachers” (p. 64). Experienced teachers are not necessarily equipped to be effective clinical educators or, in the Group’s terms, Career Professionals. Experienced teachers will not necessarily be the kind of clinical educators intent on guiding novices through meaning making activities so that novices understand what they are experiencing through varying frameworks and are able to refine their knowledge and hone their pedagogical ability.

As some of the pioneers in drawing parallels between teachers’ and physicians’ professional work, The Holmes Group (1986) expressed the absurdity in expecting modern-day physicians to practice their profession within the same framework of expectations as physicians from centuries ago. As an example, they encouraged readers to consider their physicians having no special preparation for professional practice. So, why is it acceptable for teacher-practitioners, as well as those preparing teacher-practitioners, to have no special preparation? The Holmes Group envisioned a workforce with “Career Professionals” (p. 8). These expert practitioners would be similar to people the present study is interested in, “clinical professors in medicine” (p. 8). They believed such professionals should enjoy autonomy, have an area of expertise, and “reap the rewards of professionalism” (p. 8). Some of these professionals would, through their attainment of “the highest license in teaching,” be largely responsible for the ongoing “supervision and education of practicing teachers” (p. 12). The Holmes Group’s work assumed a view of clinical educators as professionals integral to the profession’s standing and advancement. This is evident in their suggestion that teacher-practitioners develop their professional practice by working alongside and learning from Career Professionals and is further exemplified by their proposition that practitioners who are “sufficiently gifted and willing to invest the time in
advanced study and examinations” (p. 9) potentially serve as Career Professionals (i.e. professionals akin to medicine’s clinical educators).

Noticeably, teaching’s clinical practice experiences differ from some of what is commended about medicine’s. One example is that clinical practice experiences offered to preservice teachers tend to occur at few locations—sometimes occurring at a single school. Medical students work in a variety of clinical settings and residency continues to offer opportunities to practice in myriad settings with diverse patient populations. Since at least the time of the Holmes Group (1986) report, the need to allow novice teachers to experience clinical practice in varied settings and with heterogeneous student populations has been noted: “Clinical practice experiences must occur in multiple sites to provide learning opportunities with youngsters of diverse ability, motivation, and cultural background” (p. 55). Influential in establishing conceptual groundwork for modeling teacher education after medical education, the Holmes Group proposed developing Professional Development Schools—“the analogue of medical education’s teaching hospitals” (p. 56), as the varied contexts where clinical practice should be located. They believed the PDS environment could help alleviate some of the problems still present in teacher education. For example, research done by university based faculty being utilized in the P-12 environment, P-12 practitioners collaborating with university faculty to conduct inquiries on teaching and learning issues, and a more collaborative approach to student teacher supervision.

Lamentably, not enough has changed from the time the Holmes Group (1986) identified issues in teacher education’s clinical practice experiences and made propositions for reform. Despite clinical practice experiences (e.g. final internship/student teaching experience) being touted as highly constructive by student teachers, the Group identified them as “neither broad nor
deep” (p. 55). One recent piece focused on teacher education’s clinical education that has received much attention is *Transforming Teacher Education Through Clinical Practice: A National Strategy to Prepare Effective Teachers*. A Blue Ribbon Panel (2010), commissioned by the National Council for Accreditation of Teacher Education (NCATE), wrote the report. Studying the field, the Panel found that too little is known about clinical preparation, it remains ill defined, receives insufficient support, and, holding particular resonance with this study, many states fail to “specify what the roles and requirements of mentors should be” (p. 3). The Panel called for clinical practice to be placed at the core of teacher preparation and all other experiences (e.g. coursework) to be “woven around” it (p. 5).

According to the report, research on the particular reasons clinically grounded preparation is effective remains anemic. Since the final internship experience is a kind of clinical practice, and cooperating teachers ought to help student teachers make meaning from clinical practice experiences, it’s important we garner descriptions of how CTs make sense of their role in helping novice practitioners make meaning from authentic clinical practice. In doing so, we may be better situated to offer clinical educators the kind of preparation and professional development opportunities they need as they carry out the important work of preparing novices to practice independently. Related to the present study’s interest in describing how professional educators make sense of *their* role in helping novice practitioners make meaning from authentic clinical practice, the Panel highlights the complexity of teaching as a professional practice. More specifically, they note how novices need guidance from effective clinical educators in making sense of their experiences through activities like reflection and “theoriz[ing] their work” (p. 9). Clinical practice is an important time to help student teachers develop the habits of mind and action needed for them to study their professional practice throughout the professional lifespan.
The Holmes Group (1986) noted that helping preservice teachers develop the habits of mind requisite for strong classroom teaching was missing from clinical education. Both teacher and medical educators acknowledge the importance of placing professional learning and development along a continuum extending beyond preservice preparation (Feiman-Nemser, 2001a; Nasca, 2012). The Panel’s report points to the importance of using an “inquiry stance” when teaching in the clinical setting. It is fitting to prepare novices for professional practice by using the same sorts of methods they ought to apply when practicing independently (Bransford, Darling-Hammond & LePage, 2005). The Panel’s recommendation that clinical educators’ voices play a part in determining whether or not student teachers are prepared to practice independently follows. They believe that efforts need to be stepped up in ensuring that clinical educators are chosen and prepared for their position through “rigorous criteria” (p. iii). If the ways cooperating teachers help novices make meaning from clinical practice experiences have implications for how novices go on to practice, it’s essential that they are thoughtfully selected and not left to fend for themselves as they carry out their work with student teachers in the P-12 context.

Throughout their report, the Panel draws several parallels to medicine. For one, the authors characterize teaching, like medicine, as “a profession of practice” (p. 2). The point serves to further reiterate their recommendation that clinical practice be “at the center of teaching preparation” (p. 2). Panel members also believe school districts ought to implement staffing models similar to those used in teaching hospitals. Their view is that doing so will strengthen clinical practice teams and the strengthening will be evident through all team members working together to support both student teacher and P-12 student learning. A problem also documented in the medical literature (Cooke, Irby, & O’Brien, 2010; Harden and Crosby, 2000; Josiah Macy
Jr. Foundation, 2010), the Panel believes higher education institutions need to “legitimize the role of clinical faculty” (p. 19). As presently structured, individuals who may have each an interest in and the right mix of dispositions and skills for clinical education may not become involved with the work because it won’t prove productive toward securing tenure and promotion. Accentuating the important role of the clinical educator, the Panel writes, “[M]astery and fluency comes, in large part, through robust opportunities to develop as practitioners via expertly mentored experiences in the field…” (p. 27). Those from the P-12 school system serving as cooperating teachers must be recognized as important players in the teacher preparation process and should be rewarded as such. Presently, cooperating teachers receive little to no compensation for the important work they carry out. Though the Panel makes mention of the simulated practice opportunities afforded to some medical students, it is documented in the medical education literature that the faculty charged with guiding medical students through such experiences are not always trained in teaching methods specific to clinical education (Catto, 2000, as ctd. in Dent, 2001). While I respect the Panel’s work, some of the connections they attempt to make to medical education appear to lack solid grounding in the medical education scholarship. Although teacher education stands to learn from how medical education conceptualizes and enacts clinical practice, it is also important to have an understanding of the challenges and shortcomings in their field. My own vision for teacher education aligns with Cooke, Irby, & O’Brien’s aforementioned position that carefully sequenced, early, and authentic clinical practice experiences ought to instill novices with the habits of mind and action that position professional practice as a force behind professional development intentioned on further developing the varied domains of exemplary professional practice and the multifaceted professional role.
**Medicine & Teaching as Professions**

Given the participants and contexts for the present study, some discussion on both teaching and medicine as professions is important. In their formative report on teacher education, The Holmes Group (1986) identified teacher education as “intellectually weak” and linked this weakness to a continued wearing away “of an already poorly esteemed profession” (p. 6). The lack of intellectual muscle, coupled with a low status, led to an influx of poorly prepared teachers in the Nation’s classrooms. Their vision for a teaching workforce consisted of a variety of teaching positions, each with unique entry requirements. Included in the vision’s purview was a “constructive professionalism [, which included incentivizing]…learning…serious inquiry…and…helping others to improve” (p. 9). The problem with achieving this “constructive professionalism,” the Group believed, rested on education reformers’ shoulders—some of those reformers being teacher educators themselves. Holmes Group members identified teachers’ low professional status as “the central issue in the improvement of teaching” (p. 61). If reform efforts continued to be grounded in a stripping of teacher autonomy rather than teacher professional development and empowerment, teachers’ low professional status would remain the same. “Reform advocates,” they wrote, “have never fully appreciated the fact that the problems of teacher education mirror society’s failure to treat teaching as a profession” (p. 61). At present, it is unfortunate that not much progress has been made on this front. Use of scripted curricula is on the rise and cooperating teachers remain both largely unrecognized for their work and detached from important decision-making and preservice preparation occurring in the university/college of education context.

Similar to others who would come years later (Bok, 2013), The Holmes Group (1986) pointed out that some of the world’s best examples of professional education are located within
our nation’s higher education institutions. They made specific mention of medicine, business, and law and argued that if it is possible for those professions to provide high quality professional education within the nation’s universities, it should be possible for colleges of education to do the same. Stonewalling teacher education’s ability to become a strong example of professional education is teacher education itself. Different from the upper professions, teacher education has failed to establish a “specialized [body of] knowledge, codified and transmitted through professional education and clinical practice” (p. 63). If no specialized body of knowledge for teachers to master exists, and there are no unique clinical practice experiences for novices to be guided through by expert practitioners, why wouldn’t the perception that anyone can teach persist? Why would teacher education be viewed as a necessary process?

Discussion of teaching as a profession should also address Schon’s (1983, 1987) work, which looked at several professions and their professional education. The professions, including medicine and teaching, have come to be a necessary part of our society. We trust that professionals, like physicians and teachers, have unique “professional knowledge” enabling them to enact the professional role for the betterment of the population(s) they serve. Schon (1983) explains how society has come to “look to professionals for the definition and solution of [its] problems” (pg. 3-4). We enter relationships with professionals trusting they will demonstrate professional judgment to help us successfully identify and work through our problems. A resident physician trusting the attending, a student teacher the CT, a patient his novice physician, and a student his neophyte teacher. But, Schon details a “crisis of confidence” that has taken hold both within professions and in public attitudes about professions. What are professionals to do about defining and working to solve within-profession-problems? What is the professional knowledge required for such activities? Why should the public trust that professionals are using
their professional knowledge and autonomy for the greater good and not primarily (solely) for individual profit? Swick (2000) explains that since professions have a sort of “monopoly over [their] work, [they] enjoy [the] relative autonomy that derives from the nature of the work performed and from the relationship of the profession to institutions external to it” (p. 613). In Schon’s view, the crisis of confidence found within professions and pointed toward professions from the public is bound up with “question[s] of professional knowledge” (p. 13). Schon asks, “Is professional knowledge adequate to fulfill the espoused purposes of the professions? Is it sufficient to meet the societal demands which the professions have helped to create” (p. 13).

Regarding clinical practice experiences, and how clinical educators make sense of their role in helping novices make meaning from those experiences, it’s important to understand what clinical educators believe constitutes professional knowledge, the level of importance they give it, and how (if) they help novices connect it to the experiences they have when enacting the professional role.

Holding resonance with the present study is Schon’s (1987) assertion that professional schools have attempted to elevate their level “of academic rigor and status” (p. 9) by modeling themselves after undergraduate medical education. The model of medical education thought by other professional schools as worthy of emulating privileges “General, theoretical, propositional knowledge” (p. 9). The hierarchical view of knowledge, evident in medical education today, places the basic sciences at the top, followed by applied sciences, and the techniques and skills associated with the daily tasks of professional practice are at the bottom. Cochran-Smith and Lytle’s (1999) conceptualization of “knowledge-for-practice” parallels the prominent view that medical students must amass large amounts of scientific knowledge before they can begin applying knowledge in clinical practice settings. Cited by Cochran-Smith and Lytle as a
“prevalent conception of teacher learning,” (p. 253) this view of knowledge assumes that when learners have larger repositories of knowledge they will practice more effectively. Implicit in the aforementioned hierarchy of knowledge, and counter to Cochran-Smith and Lytle’s conceptualization of each knowledge in and of practice, is that the knowledge generated by professional practitioners as a result of their practicing the practice is neither (a) as legitimate as knowledge generated in the research university nor (b) as necessary as “scientific knowledge” in preparing novices to enter clinical practice experiences. This, too, runs counter to the aforementioned Panel’s recommendation to place clinical practice at the core of teacher education with all other features wound around it. Still, what has been deemed a “minor profession” (Glazer, 1974, as ctd. in Schon), education continues seeking acknowledgement as a major, upper profession by adopting medicine’s sequences of knowledge transmission and clinical practice. Ironically, medical education reformers recognize the knowledge hierarchy as problematic and are working to create more coherence between the professional school and the professional practice context. Swick (2000) calls on Freidson’s (1988) work, anchored by a sociological framework, which identified medicine as the profession “representative of all professions” (p. 613). A more recent text that might underscore the view of teaching as a lower profession is Bok’s (2013) *Higher Education in America*. Bok included three professional schools in his discussion of professional education: medicine, law, and business. He explains that the three chosen professions share enough with those left out that his choice is “defensible, if not ideal” (p. 250). Though “what to teach” and “how to teach” are sections of each of the three professional education chapters, teaching as a profession is omitted.

Schon’s (1983, 1987) work, considering how long ago it was written, points to how slow a process it can be for change (e.g. mindset; professional values) to take hold within a
professional school. Twenty-seven years ago he noted how professional schools recognized that assumptions undergirding the professional education process, like the hierarchical view of knowledge, may be ill suited for preparing novices to enter the professional practice context. If professional schools continue privileging “scientific,” academic research as the primary and most useful source of knowledge for transfer to novice practitioners, novices aren’t likely to enter clinical practice experiences with the habits of mind needed to further cultivate and develop an inquiry stance (Cochran-Smith & Lytle, 1999) toward practice. Such a stance has been identified as an integral part of the professional formation process, extending throughout the professional lifespan, in each the teaching and medical profession. Quoting an engineering school dean, Schon (1987) includes the following point to illustrate the problematic nature of professional schools’ predominant, hierarchical view of knowledge: “we know how to teach people to build ships but not how to figure out what ships to build” (Kyle, 1974, as qtd. in Schon, p. 11). The dean’s words underscore a problem persisting today. Bok (2013) claims that in order for novices to thoughtfully consider weighty questions within the profession they must “first…be conversant with the principal problems facing their profession” (p. 314). As most commonly prepared for professional practice, novices are not taught in ways supporting development of the habits of mind and action needed to problematize practice and continually develop as professionals while also contributing to the profession. Swick (2000) writes, “The demands of intellectual work require that physicians maintain the highest standards of excellence through the continuing acquisition of knowledge and the development of new skills” (p. 613). This is no different for teachers, who are also engaged in complex intellectual work. Through the ways they are prepared for entry into independent professional practice, novices need to understand that “A commitment to excellence makes life-long learning fundamental to professionalism” (Swick, p.
613). Though only one appears to have legitimacy as an upper profession, teacher and medical education are plagued by some of the same issues regarding how to best prepare novices so that they enter professional practice on a trajectory for developing into expert practitioners. One ongoing debate is about the best sequencing of professional-school-based and professional-practice-context-based learning experiences. Similar to teacher education, Bok (2013) explains that there are still medical educators who favor the traditional method of frontloading professional education with classroom-based learning in the basic sciences. Others believe varying kinds of clinical practice experiences should begin as early as possible. As Bok notes, studies attempting to determine which method is best have failed to confirm either approach as most effective. Hunter (1991) points out that medical professionals are set apart by “their education and experience” (p. xviii). She further writes, “‘Science’ serves as the sign of their special knowledge” (p. xviii). Neither profession has definitively figured out the complex task of organizing clinical practice experiences in ways proving most productive during professional education. Within teacher education, we have no well-defined answers as to why clinical practice experiences, at any point in the professional education process, are effective.

It might be because teaching often takes a backseat to research that both professions lack understanding of how to best organize clinical practice experiences and why they are touted as so important. Bok (2013) documents how, due to things like the large sums of grant dollars given to medical schools by the National Institutes of Health, research demands more of faculty members’ attention than teaching. There is of course great irony in that two professions where teaching is—or ought to be—central, it is not highly respected work. In medicine, for example, some residents go straight from residency into jobs as clinical faculty members. Meaning, they both teach and practice in the same hospital. Yet, due to the low status of teaching and ill-defined roles of
clinical educators, these new faculty members are unlikely to have received any extensive, formal preparation on how to teach in the clinical setting. A focus on grant dollars, Bok explains, impacted clinical education because it led to medical schools hiring practitioners as faculty and “some…lacked any teaching…experience” (p. 265). Teacher education continues the practice of utilizing graduate students as university supervisors during student teachers’ culminating internship experience. Due to the low status of fieldwork, and what is deemed as most important by higher education institutions (e.g. securing large grants), faculty on tenure and promotion tracks might feel forced out of focusing on studying varying facets of clinical practice.

**Current Knowledge about Clinical Educators**

Though there are a number of gaps in the literature on clinical education, there are some important things we know about those working as clinical educators. Still, it’s important we continue work aimed at reaching better understanding of the clinical educator’s role. Considering a point like Swick’s (2000), that there has been a longstanding concern “about the impact physicians’ behaviors have on the professional development of medical students and residents” (p. 615), the need for this understanding may come into clearer focus. Certainly, Swick’s point is applicable in the teacher education context. The problem of cooperating teachers being unprepared for their role and even doing the role involuntarily has persisted for some time. The Holmes Group (1986) wrote, “Mentor teachers are often selected by school officials with little understanding of the particular learnings to be acquired, and with little appreciation for the professional knowledge of competent teachers and teacher educators” (p. 54). As is still the case today, with cooperating teachers going predominantly unpaid for the role, so was the situation at the time of the Group’s report. They advised monetarily compensating CTs, whom they conceived as working both in the professional development school and university settings, for
their professional responsibilities. One of the things we know, in both professions, is that the professional practice context is marked by regular change. Changes in how P-12 education and healthcare are delivered can impact how clinical educators deliver clinical education.

To continue with an illustration from P-12 education, teachers’ pay is more commonly being tied to how their students perform on mandated, standardized assessments. In turn, increasing numbers of cooperating teachers are hesitant to eventually relinquish complete control of their classrooms to student teachers. To a certain extent, this is because those charged with determining the professional teacher’s performance pay are not going to account for the fact that an intern was responsible for teaching students for part of the year. Hence, P-12 students’ scores may be lower because of the novices’ pedagogy and not, solely, because of the cooperating teacher’s. Student teachers, then, are missing out on important time independently enacting the role of the teacher. Under present conditions, student teachers miss out on opportunities to run the classroom space without the CT also being present. Additionally, under such circumstances, CTs may decide to retain a bulk of the teaching duties. Though some of these issues point to teacher education problems beyond the scope of this study, and though I do not support leaving student teachers to fend for themselves for the entirety of the clinical practice experience, the points raised serve to highlight some current concerns with the clinical educator’s role in the present professional practice context.

To share an illustration from the medical profession, our nation’s vast and complex healthcare system continues seeing changes in how patient care is delivered. Bok (2013) elucidates on how these changes impact clinical educators’ work. Presently, physicians spend more time in the ambulatory setting (e.g. an outpatient clinic) than in the hospital setting. A change in setting, combined with demands placed on physicians to increase efficiency, results in
clinical educators having less time to spend with novices. In turn, learners look to “interns and residents for their education” (p. 266). Though the fact that practitioners across years of experience at times function as clinical educators in the medical education context is positive, it’s essential novices have extended time to learn with and from seasoned practitioners who have also demonstrated exemplary clinical education practice. Similar to what is happening with student teachers, Bok notes that many physician-clinical-educators are choosing to have novices observe rather than participate in patient care because the mandates placed on them (e.g. paperwork) are too great to meet in a timely manner while efficiently managing the patient load and also creating time to teach novices about varying arms of practice. A concern with efficiency at teaching hospitals, also explains Bok, has led to a surge in employing hospitalists (a relatively new medical specialty) to look after large numbers of patients and medical students. While it’s a good thing clinical education was accounted for, Bok writes, “Although hospitalists have apparently improved patient care, they often lack the experience or even the time to serve effectively as teachers and mentors” (p. 266). Irby (1994) has identified how clinical educators serve as powerful role models. But, Bok expounds on how novices are losing out on opportunities to learn from positive examples of role modeling because clinical educators are increasingly interested in fulfilling research responsibilities, improving their own efficiency, and earning additional income from ancillary activities (e.g. speaking engagements contracted out by pharmaceutical companies). These practices, on clinical faculty members’ part, tend to point to their “favor[ing] the status quo” (Bok, p. 267) when it comes to their work with learners.

As will be discussed in greater detail in chapter two, clinical educators in both professions play an important part in novices’ learning and development. It is key, for the future of both professions, that clinical educators are practitioners who are well prepared for the tasks
of clinical teaching and committed to upholding the profession’s standards. If those charged with clinical education do not make that role and its responsibilities a priority, clinical education will not help instill novices with the habits of mind and action needed for field-building (Cooke, Irby, & O’Brien, 2010), as achieved through inquiry as a professional stance (Cochran-Smith & Lytle, 1999) and a dually informed and intentional pushing against the status quo. The role of clinical educator cannot continue being filled by practitioners who are ill prepared to carry it out. Further, just as “doing the profession” (Shulman, 2005b) well requires a cadre of professionals who are committed to and motivated by the work, so too does the clinical education aspect of the profession. Those enacting the clinical educator role should be professionals who have made a conscious decision to do so and they should be compensated for the complex work.

Table 1.1: Shared Challenges of Clinical Educator Role

<table>
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<th>Clinical educator: What we know</th>
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<th>Medicine</th>
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<td>Lack of preparation for role</td>
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<td>Lack of compensation</td>
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*Shared challenges of clinical educator role*

**Statement of the Problem**

We know too little about how professional educators (cooperating teachers and attending physicians) make sense of their role in helping novice practitioners make meaning from authentic clinical practice (Harden & Crosby, 2000; Steinert, 2014; Wilson, Floden, & Ferrini-Mundy, 2001). Considering each profession’s interest in learning from the other, and ongoing efforts in each field to revise clinical practice experiences (Josiah Macy Jr. Foundation, 2010;
NCATE Blue Ribbon Panel on the Transformation of Teacher Education through Clinical Practice, 2010), there is a need for scholarship simultaneously looking at particular features of experiential learning in medical and teacher education (Irby, 1994; Kilminster & Jolly, 2000; Swanwick, 2014). Exemplary descriptions of teaching and learning in the clinical practice context include educators enacting their professional role so that they guide novices through cognitive and practical activities that support the development of professional formation—a process extending throughout the professional lifespan (Cooke, Irby, & O’Brien, 2010; Wear & Castellani, 2000). Regardless of how involved clinically based professional educators are in novices’ meaning making from clinical practice experiences, novices will make meaning as a way to fill perceived conceptual gaps and successfully navigate through the professional practice context they are immersed in. The meanings novices make from clinical practice experiences are important and should be guided by inquiry oriented (Cochran-Smith & Lytle, 1999; Skeff, 1988) and reform minded practitioners (Feiman-Nemser, 2001a) because, as stated by Yardley, Brosnan, and Richardson (2013), they will eventually “shape future experiences as students either build further upon them, refine, or reject them…. [T]hey represent the first of the workplace transitions [novices] are required to make” (p. 118).

Purpose of the Study

The purpose of this phenomenological study is to describe how professional educators (i.e. cooperating teachers and attending physicians) make sense of their role in helping novice practitioners make meaning from authentic clinical practice. One attending physician and one cooperating teacher will serve as participants for the study, and the sample size is appropriate for the methodology. Setting their stories side by side can help speak to the interest both professions have in learning from other professional fields to improve clinical education.
Overview of the Conceptual Framework

Professional formation serves as the study’s conceptual framework. More specifically, the study will make use of Cooke, Irby, and O’Brien’s (2010) conceptualization of professional formation, which builds on Wear and Castellani’s (2000) conceptualization of the construct. The former articulate how professional formation is a practitioner’s intentional, ongoing effort to achieve “excellence across the domains of practice” (p. 38) so that conditions of the populations they serve are improved. The latter explain professional formation as “an ongoing, self-reflective process involving habits of thought, feeling, and acting” (p. 603). It is a process extending throughout the professional lifespan. Professional formation is a cornerstone in the process of preparing preservice teachers and resident physicians for professional practice.

Teacher and medical education need to better understand how clinical educators make sense of their role in helping novice practitioners make meaning from clinical practice experiences (Cooke, Irby, & O’Brien, 2010; Harden & Crosby, 2000; NCATE Report of the Blue Ribbon Panel on Clinical Preparation and Partnerships for Improved Student Learning, 2010; Steinert, 2014; Wilson, Floden & Ferrini-Mundy, 2001). When there is better understanding of how clinical educators make sense of particular facets and functions of their role, varying people involved in the professional education process will likely stand better situated to ensure that pedagogies like experiential learning support the development of professional formation (Cooke, Irby, & O’Brien; McGee & Irby, 1997).

Research Question

In order to gather descriptions of how clinical educators make sense of their role in helping novice practitioners make meaning from authentic clinical practice, the study is guided by the following question:
In what ways do professional educators (cooperating teachers and attending doctors) make sense of their role in helping novice practitioners make meaning from authentic clinical practice?

**Significance of the Study**

Though there is great interest within teacher education to model preservice preparation after medical education, clinical education most specifically, the teacher education literature does not demonstrate deep understanding of medical education (NCATE Blue Ribbon Panel on the Transformation of Teacher Education through Clinical Practice, 2010). Further, though teacher educators and scholars have studied other professions, including medicine, there is a gap in the scholarship as far as studies simultaneously looking at teacher and medical education. This is in light of the interest each field has in learning from one another and from other professions. In their report “Tomorrow’s Teachers,” Holmes Group member Judith Lanier underscored the complexity of both studying and reforming teacher education. She also pointed out: “a consortium of institutions that educate teacher educators as well as teachers is needed” (p. vii). An understanding of the need to better prepare professional educators (e.g. cooperating teachers) for their role has existed for some time. Clearly, work remains to be done on both reaching understanding of professional educators’ role and how to best prepare people for that role.

The present study stands to illuminate how each profession can, taking lessons from the other (Proctor, 2010), work toward ensuring that clinically based professional educators thoughtfully guide novices through meaning making activities that support coalescence of theoretical and practical knowledge (Feiman-Nemser, 2001a; Grossman et al., 2008; Korthagen & Kessels, 1999), an inquiry stance toward practice (Cochran-Smith & Lytle, 1999), and the reform-mindedness (Feiman-Nemser; Swick, 2000) needed for practitioners to be “field builders”
across the professional lifespan. These are important features of professional formation, which is at the core of professional education (Cooke, Irby, & O’Brien; Wear & Castellani). Given that this is a single, small study, it is fitting to suggest its findings may contribute to future studies interested in better understanding related features of clinical practice experiences.

**Definition of Terms**

- **Meaning Making** - Clinical educators and novice practitioners are constantly making meaning as both (a) a way to continue navigating through a particular professional practice context (Yardley, Brosnan & Richardson, 2013) and (b) as a result of particular transactions (Edge, 2011; Rosenblatt, 1995) they have with other people (e.g. a school or hospital administrator) and other texts (e.g. a lesson plan; a documented patient complaint) within the context. In the medical education context, the view of “patient as text” (Hunter, 1991; Irby, 1994) has been noted as integral to the teaching and learning process. The influence of “vicarious…learning” in the professional practice context is also documented in the medical education literature (Kenny, Mann, & MacLeod, 2003). Novices’ “linguistic-experiential reservoirs” (Edge; Rosenblatt) need educators’ scaffolding as they (i.e. novices) continue strengthening and contributing to them through ongoing clinical practice experiences and knowledge development. Meaning making will be defined as the professional educator’s intentional act of guiding the novice practitioner through the process of reflecting on, questioning, and/or talking about varying facets of enacted professional practice in the clinical practice context.

- **Authentic clinical practice** – The present study will make use of Yardley, Brosnan, and Richardson’s (2013) conceptualization of authentic clinical practice experiences. These
educational experiences, situated in the professional practice context, are designed to make the “human contact” (p. 109) novices have with more knowing others and the population(s) they serve act as an impetus for novice practitioners’ learning and development. For the purpose of this study, authentic clinical practice in the medical education context can be additionally understood as the period of time during Graduate Medical Education known as residency. In the teacher education context, authentic clinical practice can be further understood as the portion of preservice preparation commonly referred to as student teaching/internship.

- **Professional formation** – This study will make use of Cooke, Irby, and O’Brien’s (2010) conceptualization of professional formation, which builds on Wear and Castellani’s (2000) conceptualization of the construct. The former articulate how professional formation is a practitioner’s intentional, ongoing effort to achieve “excellence across the domains of practice” (p. 38) so that conditions of the populations they serve are improved. The latter explain professional formation as “an ongoing, self-reflective process involving habits of thought, feeling, and acting” (p. 603). It is a process extending throughout the professional lifespan.

- **Role** – The clinical educator’s professional role is multifaceted (Harden & Crosby, 2000; Shulman, 2005; Steinert, 2014) and carries with it myriad responsibilities. The professional role is made up of a mix of personal and professional qualities (Wright & Carrese, 2002) and is influenced by the situatedness of teaching and learning (Irby, 1994; Shulman, 2004). As functions (Burns, 2012; Kilminster & Jolly, 2000) of their role, clinical educators must orient novices to the professional practitioner’s daily tasks and the planning needed to prepare for those tasks. They are charged with helping novices further develop the varying bodies of
knowledge needed to enact the professional role, as well as the skills and dispositions needed to do so effectively. Arguably, chief among their functions is how they enact their role so that novices’ professional formation is positively impacted (Cooke, Irby, and O’Brien, 2010; Kenny et al., 2003). For the present study, role will be defined as the professional educator’s professional identity, which is informed by a special mix of “cognitive and behavioral processes” (Kenny et al.) that stem from personal attributes, professional knowledge, and professionally oriented lived experiences.

- **Professional educators** – This study will make use of Cooke, Irby, and O’Brien’s (2010) conceptualization of a clinically based professional educator. These educators are intentional in creating “‘learning space[s]’” (p. 135) that challenge novice practitioners, propel their learning, and do not compromise conditions for the population(s) novices work with. Feedback and the ongoing questioning of professional practice are prominent features of these learning spaces. For the present study, the professional medical educator will be a Board certified attending physician who both practices and teaches in his/her specialty, in the academic hospital setting. In the teacher education context, the professional educator will be a National Board certified teacher practitioner who also serves as a cooperating teacher to student teachers completing their student teaching/internship.

**Overview of Methodology**

Phenomenology serves as the selected research method for the present study. More specifically, Seidman’s (2013) approach to phenomenological interviewing as method will be implemented. Through the series of in-depth interviews called for by Seidman’s approach, I will seek to elicit stories from participants that help get at answers to the research question. Seidman
explains storytelling as a process that, through detail selection, sequencing, and reflection, enables the teller to make meaning.

Following Seidman’s (2013) model for in-depth phenomenological interviewing, I plan on conducting three, ninety-minute interviews with each participant. Each interview will have a particular focus and adhering to the ninety-minute timeframe is important because going over the allotted amount of time can lead to discussion that is not grounded in the study’s aim and research question. In-depth phenomenological interviewing does not employ a concrete interview guide. Though each interview can take a semi-structured format, the questions contributing to the framing of each interview are constructed from an understanding of what participants shared in previous interviews. Seidman notes, “The truly effective question flows from an interviewer’s concentrated listening, engaged interest in what is being said, and purpose in moving forward” (p. 95). Actively listening to participants and working to understand their reconstructions of lived experience, throughout the course of and between each interview, will help me look deeper into the windows of their past so that an understanding of how the past is informing the present can be reached.

Considering Polkinghorne’s (2005) suggestion, I aim to secure participants I believe are capable of and willing to articulate rich responses throughout the course of the interviews. Regarding the number of participants selected, there is no single, correct number I must secure (Seidman, 2013). A small sample size is appropriate for a phenomenological study. Hycner (1985) explains that phenomenological studies using interviewing as a tool for getting at the essence of participants’ experiences should have an intentionally limited number of people because the amount of data each interview yields may prove too much for a single researcher to thoughtfully work with. Additionally, the small sample size is appropriate for the study because
generalizing findings is neither an aim of nor possible with phenomenological studies. Securing a larger number of participants would impinge on my ability to study the phenomenon as deeply as called for (Hycner). I aim to secure two participants, one from each teacher education and medical education. The teacher educator enacting that role through his/her service as a cooperating teacher, and the medical educator enacting that role through his/her function as an attending physician at a teaching hospital. Moreover, the attending should work with a particular residency program at the hospital. Given the interest each profession has expressed in learning from the other (Josiah Macy Jr. Foundation, 2010; NCATE Blue Ribbon Panel on the Transformation of Teacher Education through Clinical Practice, 2010), it is fitting to set the stories of a professional practitioner/clinical educator from each profession side by side.

Findings will be presented following Seidman’s (2013) suggested mediums. I will focus on crafting profiles that include a clear beginning, middle, and end, as well as elements needed in stories (i.e. conflict and resolution).

Assumptions

The present study includes certain assumptions. Essential is confronting these and reflecting on them throughout the study (Lincoln, 2005; Paul, 2005). One assumption embedded in this study is that simultaneously studying a teacher and medical educator will prove insightful and potentially fill a gap in the present literature base. There is a chance that looking across participants’ stories won’t prove particularly useful in providing recommendations for clinical educators across the two professional contexts. Considering the longstanding interest to model teaching’s clinical education after medicine’s, and medicine’s interest in learning from other professions, I feel it is important to carry out the study because it is plausible that simultaneously looking at clinical educators from both professions will yield useful findings.
Though efforts will be made to select participants who can speak to the research question, there exists a chance that they will not and that interviews will fall flat. The criterion sampling strategy (Patton, 1990) serves as a safeguard for having participants who neither have experience with the phenomenon nor the ability to articulate their experiences. Further, other studies looking at features of clinical education and clinical educators have relied on items like students’ evaluations of educators to select participants (Litzelman, Stratos, Marriot, & Skeff, 1998; Wright & Carrese, 2002).

In an effort to be consistent with and intentional about considering my assumptions throughout the course of the study, I will maintain a researcher reflective journal. This will be done in place of bracketing, which is commonly associated with phenomenology. Regularly writing in the journal can help me make meaning of my experiences as the researcher and hold me accountable for how my personal and professional backgrounds may influence those experiences.

**Limitations**

As is the case with any study, this study carries with it a number of limitations. Though generalizability is not an aim of the present study, and the sample size is appropriate for the method (Hycner, 1985), there are only two participants who practice in particular contexts. There is a chance that their stories may not resonate with a large number of clinical educators.

Though I hesitate to use the term “limitation,” Seidman (2013) makes some noteworthy points that must be kept in mind when reading through the findings and profiles of a particular study. First, he writes, “[T]he narratives we present are a function of our interaction with the participants and their words” (p. 132). Meaning, though a number of medical and/or teacher educator researchers reading through participants’ transcripts may have created profiles not all-
too-different from mine, there exists the possibility they might have. The participants’ lived experiences, as related to the study, occurred before we interacted as interviewer and participant and they continued to have experiences in this realm of their lives after our final interviews. So, what participants shared as a part of our interactions happened at a particular time, in a particular context, and for a particular purpose. I cannot make a definitive claim, however, that findings may have differed if the study occurred at a different point in time.

Length of time may also be seen as a limitation. Though I will adhere to the various time recommendations made by Seidman (2013), it might be that more could be understood about participants’ experiences if I spent more time with them. Further, despite our limited amount of time together, I have to trust that participants’ are open and honest during our interviews because there are no other pieces of data being collected (e.g. field notes from my observing their interactions with novice practitioners). Due to a combination of factors, like participant selection methods and adhering to Seidman’s suggestions for the space of time, I feel assured that time will not be detrimental to the study’s purpose.

**Document Organization**

The following serves to orient the reader to how the remainder of the document is organized. The next chapter is dedicated to reviewing the literature germane to the study’s purpose and research question. It helps familiarize readers with scholarship anchoring the present study. The literature review is followed by chapter three, which delineates the study’s conceptual framework and methodology. Additionally, the research methods chapter provides readers with thorough information about the study’s participants and the contexts in which they carry out their work. Due to the complexity of the findings, the extensive interview transcripts, and the need to adequately detail each participant’s story, the findings section of the study consists of three
chapters. Chapters four and five provide a profile of each participant and include interview transcript excerpts. In this way, readers can get to know each participant before looking across the pair. Chapter six is an across-participant-description. Here, readers can learn more about Tom and Tori in tandem. Finally, in chapter seven, I discuss the study’s findings in light of the literature and conceptual framework. I also provide points for consideration for the professional fields of each teacher and medical education, as well as areas for further exploration.

Chapter Summary

I began this chapter by providing some contextualizing information to illuminate how my professional and personal lives interacted in ways that contributed to my interest in professional education and clinical education in particular. The chapter provided readers with necessary background information, an articulation of the problem, and an overview of each the conceptual framework and the research methodology guiding the study. Using Seidman’s (2013) phenomenological approach to interviewing, the following research question will be explored: In what ways do professional educators (cooperating teachers and attending doctors) make sense of their role in helping novice practitioners make meaning from authentic clinical practice?

In order for readers to understand how terms salient to the study are conceptualized for the purpose of the study, definitions were provided. I was also clear about assumptions nested in the study and the study’s limitations. Likewise, I articulated that I will maintain a researcher reflective journal. In this way, my assumptions and both personal and professional experiences, which have the potential to influence how I interact with participants and make meaning throughout the study in my role as researcher, can be confronted.
CHAPTER TWO: REVIEW OF THE LITERATURE

Context of the Chapter

The second chapter provides readers access to the literature informing the present study. Specifically, scholarship needed in order to establish a need for the study and conceptual ground for the study’s exploratory question. As a precursor to the literature review, I will provide a brief synthesis of key areas presented in chapter one. An understanding of those areas is foundational to what will be discussed here.

Chapter one familiarized readers with how my personal and professional lives intertwined and brought me to the present study. As will be made clear in chapter three, van Manen (1984) writes about the importance of discovering how one comes to be invested in studying a particular phenomenon. Included in chapter one was substantive discussion of how each professional field has developed to its present state. I also provided information about each profession’s clinical practice experiences, which play a significant part in this study. Rather than providing further details about clinical practice experiences, chapter two will focus on the clinical educator’s role. Though each field has expressed interest in learning from the other, it is well known that the two professions don’t enjoy the same levels of prestige and autonomy. Hence, chapter one addressed differences in medicine and teaching as professions and how those differences translate to professional practice. Chapter one additionally detailed some of what we know about clinical educators’ challenges in each field’s present professional practice context.

An overview of the study was presented in the preceding chapter. Readers were introduced to the problem, research question, conceptual framework, and methodology. Chapter
two will provide literature relevant to understanding the problem and research question, as well as elaborate on the conceptual framework. The study’s methodology will be discussed fully in chapter three.

Essential to a formal study is a thorough review of the literature. Through a systematic literature review, beyond ensuring my own deep understanding of both the bodies of knowledge and scholarship relevant to the present study, I am able to connect my work to an expansive and complex knowledge landscape. The literature review allows me to situate my work among the scholarship and knowledge bases informing it, hence demonstrating the present study is (a) grounded in an understanding of the pertinent historical contexts of each teacher and medical education and (b) connected to the present conditions in each. The purpose of this study is to describe how professional educators (i.e. cooperating teachers and attending physicians) make sense of their role helping novice practitioners make meaning from authentic clinical practice experiences. The study is guided by the following exploratory question:

In what ways do professional educators (cooperating teachers and attending doctors) make sense of their role in helping novice practitioners make meaning from authentic clinical practice?

Each meaning making, authentic clinical practice experiences, and the task of preparing novice practitioners for professional practice are complex and multifaceted topics. For the purpose of this literature review, I focused on the following areas (a) what we know about each the cooperating teacher’s and the attending physician’s role in clinical education, (b) meaning making during clinical practice, and (c) seeking out whether or not any studies have previously compared clinical practice in the two fields. Given the multifaceted nature of these topics, there
is overlap among them. Though the overlap may be apparent in the following literature review, the intent was to develop each area as fully as possible.

**The Attending’s Role in Clinical Education**

Similar to the CT in teacher education, attending physicians serving as clinical educators play an important role in novice physicians’ developing practice. Whether or not their behaviors are exemplary, they are powerful role models. Despite the important work these clinical educators carry out and the influence they have over novices, their role remains ill defined and in need of better understanding. As explained by Harden and Crosby (2000), if the clinical educator’s role is not well understood, efforts to improve pedagogy and establish a system that rewards teaching will be thwarted.

The clinical educator role is undoubtedly complex. This complexity, coupled with the evolving nature of the role, has made it difficult to reach consensus about exactly what the role entails (Harden & Crosby, 2000). Conceptualizing roles as the “responsibilities of a teacher” (p. 336), Harden and Crosby created a descriptive framework delineating twelve roles of the medical teacher. All roles included in their framework were confirmed by use of a questionnaire given to 251 medical educators. The roles, or responsibilities, are as follows: learning facilitator, on-the-job role model, teaching role model, lecturer, clinical teacher, resource material creator, study guide producer, course organizer, each curriculum planner and evaluator, student assessor, and mentor. A shortcoming of the authors’ work is that the role of clinical educator is strongly associated with being an “information provider” (p. 336). In the authors’ framework, clinical teaching and lecturing are couched within the view of teacher as information provider. It is problematic to view clinical educators primarily as lecturers who simply transmit their “disciplinary knowledge” (p. 337) to novices. Harden and Crosby believe that, during clinical
practice experiences, “the most important factor related to student learning may be the quality of the clinical teacher” (p. 338). It’s not a stretch to claim that the highest quality clinical teaching isn’t primarily characterized by lecture. Rather, as somewhat ironically pointed out by the authors, clinical teaching must give students access to the educator’s ways of knowing and thinking in the professional practice context. As such, novices can better understand clinical educators’ ways of doing and use these ways of knowing, thinking, and doing when they make meaning of clinical practice experiences and enact the professional role. Ultimately, the authors’ work, similar to that of Burns’ (2012) in the teacher education scholarship, provides a means for further exploring and reaching understanding about the “functions” (p. 342) of the medical educator—who is sometimes a clinical educator.

It is well documented that clinical educators serve as powerful role models for the novices placed with them (Harden & Crosby, 2000; Wright & Carrese, 2002). Wright and Carrese used in-depth interviews (N = 29) as a way to, speaking directly with physicians who were identified as strong role models, gain increased understanding of what good role modeling entails. Identifying role modeling as an “integral component” of educating physicians, the two write, “Physician role models affect the attitudes, behaviours, and ethics of medical learners and foster professional values in trainees” (p. 638). Data revealed role modeling as an amalgam of personal, pedagogical and clinical skills that physicians could both learn and refine throughout the course of their career. Their conceptual model comprises the areas of personal qualities and teaching skills. Among others, “interpersonal skills” and a “commitment to excellence and growth” (p. 639) were identified as essential personal qualities. Teaching skills included the ability to create “rapport with learners” and demonstrating dedication to their growth (p. 639). One essential feature of role modeling identified by participants is their intentionality in thinking
about their role when engaged with medical learners. Participants expressed their awareness, or “role model consciousness” (p. 641), that novices are paying close attention to what they (i.e. role models) say and do in their varied interactions in the professional practice context. A mark of distinction in role modeling is using consciousness of one’s role and of novices’ observations to help one act in ways upholding the profession. Wright and Carrese suggest that the strongest role models might use the above-mentioned awareness to create teaching situations during which they can model “often neglected aspects of medicine and professionalism” (p. 642) and, of great importance, spend time with novices discussing what they modeled. Steinert (2014) notes the importance of “understanding the power of the unconscious” in role modeling (p. 461). Without engaging learners in discussions during which modeled behaviors are “unpacked” (Ball & Cohen, 1999), misconceptions may persist and opportunities for learning lost. Harden and Crosby (2000) view role modeling as an influential means for “transmitting values, attitudes and patterns of thoughts and behavior to students” (p. 338). Problematic with “transmitting” is the implication that there exists no explicit discussion of what novices observe. It’s key that clinical educators help novices make meaning because not doing so may lead to misinterpretations that negatively shape habits of mind and action.

One of the problems plaguing medical education is that though physician educators may be expert practitioners within their specialty, they are likely to have minimal preparation for teaching novice practitioners how to enact the multifaceted professional role (Steinert, 2014). The absence of a formal system for preparing medical educators contributes to lack of consensus on what the term “medical educator” means. The “apprenticeship of observation” (Lortie, 1975), known to inform how teaching is enacted in P-12 schools, is also prevalent in medical education (Irby, 1994; Steinert, 2014). Steinert notes the popular assumption that through being a learner
for an extensive amount of time, as is the case with physicians, one can somehow learn how to teach the many components of a discipline. Though there is increasing interest in the role of medical educator and how to prepare practitioners for that role, past attitudes have contributed to an environment in which, since the role is ill defined, effective professional development opportunities remain difficult to organize and sustain. Steinert anchors her work on how medical educators can be prepared for their role by offering the following as a way to understand the role. She asserts that “medical educator” is made up of a range of roles including “teaching, curriculum design and evaluation, educational leadership and innovation, and research and scholarship” (p. 456). In order for professional development opportunities to take hold, it’s important the role of medical educator be professionalized (Swanwick, 2008, as qtd. in Steinert).

An important part of the teacher education process is helping preservice teachers come to own sets of conceptual frameworks they can use when planning for teaching and when attempting to make meaning of lived teaching experiences (Hammerness et al. 2005; Grossman et al., 2008). A goal of professional development opportunities for medical educators must be to “provide…conceptual framework[s] for what is often performed on an intuitive basis…” (Steinert, p. 456). Just like those serving as cooperating teachers, it’s essential that physicians serving as clinical medical educators have the ability to articulate the thought processes, knowledge bases, and rationales informing their actions. At present, medical educators are prepared for their role, primarily, by learning on the job. Steinert suggests, in light of the present system, that medical educators work to form communities of practice and use the clinical practice context, where practitioners and novices work together, as a site for formal reflection and inquiry. This view aligns with Cochran-Smith and Lytle’s (1999) inquiry stance. When novices are prepared for professional practice through communities of practice, partly
characterized by intentionality toward discussing and studying varying facets of practice, it can help medical educators more effectively prepare them for the role of teacher they are likely to someday assume. Beyond the fact that residents will eventually be charged with teaching both more junior residents and medical students completing clerkships, they will also find that stepping into the role of teacher is an integral part of their interactions with patients (Dandavino et al., 1986, as ctd. in Steinert). Before meaningful professional development opportunities can be created for medical educators and novices, it’s important that work is done to better understand the medical educator’s complex role.

On the whole, both clinical education and the role of clinical educator remain understudied features of medical education (Kilminster & Jolly, 2000; Steinert, 2014). Steinert suggests conducting studies aimed at better understanding the experience of being a medical educator. Higgs and McCallister’s (2007) work, though they studied speech pathologists serving as clinical educators, can help contribute to an understanding of being a clinical educator in the medical education context. Their work, which employed hermeneutic phenomenology and narrative inquiry methodology, helped create a model of “The Experience of Being a Clinical Educator” (p. e51). Six dimensions make up the model, which the authors believe can be used to prepare clinical educators in other professions since there are commonalities cutting across profession boundaries. Dimensions are sense of self, sense of relationship with others, sense of being a clinical educator, sense of agency, dynamic self-congruence, and experience of growth and change. Elements of the model’s dimensions are ones that, ideally, will also be developed in novice practitioners through the explicit attention clinical educators give them. Such elements include a commitment to lifelong learning, working to interact well with others so as not to become an insular practitioner, understanding one’s role (i.e. as a clinical educator), taking
action to manage oneself and others, focusing on how to marry facets of the role, and “pursuing professional artistry” (p. e55). Like Steinert, Higgs and McCallister believe that understanding the complex role of clinical educator can be instrumental in designing professional development opportunities to prepare physicians for the role. The experience of being a clinical educator can itself be influential professional development. As the two authors express, “[I]nteractions with students and learning from those interactions are powerful professional development opportunities for clinical educators” (p. e56). Given the similarities in the potential for professional learning and development apparent during the clinical education experience, for novice and educator, it’s essential that efforts to better understand the role of clinical educator be pursued so that opportunities for learning are capitalized on by all involved.

Hesketh et al. (2001) recognize the need to professionalize teaching within medical education. They further note the importance of properly preparing medical educators for their role, and their work provides a twelve-outcome-framework for doing so. Acknowledging shifting attitudes in physicians’ preparation for teaching, they document “the move away from the ‘apprenticeship’ model to experiential learning for work-based learning” (p. 556). But, it is beyond difficult for physicians who have received no formal preparation for the role of teacher to move beyond a traditional apprenticeship approach and support novices’ experiential learning experiences by engaging them in appropriate educational activities: these include guided reflection and sessions aimed at unpacking moments of enacted practice. The authors claim that their outcomes based model can assist in (a) creating curricula for preparing medical educators and (b) educators’ ongoing, individual professional development. Their model, which was developed after examining both the relevant literature and curricula from classes specifically for medical educators, includes the following outcomes: ability to (a) teach varying numbers of
students simultaneously, (b) teach in the clinical setting, (c) evaluate individual learner’s progress and assist them accordingly, (d) study relevant features of medical education and practice, (e) articulate theories undergirding particular pedagogical methods, (f) integrate the role of teacher with that of medical practitioner and, (g) demonstrate a commitment to professional development across the professional lifespan. On the whole, the group believes the model helps to fill a gap in the medical education literature by “describing the effective teacher in the clinical setting” (p. 564). As such, it can be useful to—and further refined by—both those preparing physicians for the role of educator and clinical medical educators.

Kilminster and Jolly’s (2000) work also attempted to identify the characteristics of effective supervision. The two conducted a “large-scale, interdisciplinary” (p. 827) literature review because, despite its importance in GME, clinical supervision is not well studied. The authors, who included teacher education within the scope of their review, note that, not unlike teacher education, medicine’s clinical supervision is currently guided by scant evidence-based practices. Like teacher education, assumptions guide much of the decision-making and supervisory work (Darling-Hammond & Bransford, 2005; Grossman et al., 2008). Resonating with the present study, the authors hold that medical education stands to learn from how other professions (e.g. teaching) carry out supervision. They define supervision within the medical education setting as “the provision of monitoring, guidance and feedback on matters of personal, professional and educational development in the context of the doctor’s care of patients” (p. 828). They also note that the clinical educator must be adept at foreseeing novices’ varying strengths and weaknesses because, in the clinical setting, patient safety cannot be compromised. The importance of developing the ability to anticipate learners’ misconceptions is also documented within the teacher education literature (Grossman, 1990). Another similarity to teacher
education’s supervision apparent in both Kilminster and Jolly’s and Proctor’s (2010) work is the effort to further develop understandings of the supervisor’s “functions” (Burns, 2012). Viewing functions and roles of supervision as interchangeable, Kilminster and Jolly’s review revealed that, in medicine and teaching, “management, education and support” (p. 829) held as important functions/roles of the clinical educator’s work. Aligned with those who support an outcomes based approach (Hesketh et al., 2001), Kilminster and Jolly found that, across professions, there is agreement—though not a solid research base—that “learning objectives [should be] determined at the beginning of the supervisory relationship” (p. 831). In this way, individual novice practitioner’s learning experiences in the clinical setting can be better designed to meet them where they are. However, a problem also identified by Yardley, Brosnan, and Richardson (2013), which has implications for clinical educators’ ability to tailor novices’ learning experiences, is that learners come up with ways to appear proficient though they need additional scaffolding of learning experiences and guided, “deliberate” (Erickson, 1996) practice with their clinical educator. Perhaps one way for clinical educators across professions to safeguard against learners not fully disclosing areas in which they need additional support is to be consistent with and intentional in efforts to establish and maintain an honest relationship with novices. Similar to teacher education, one of the greatest challenges in providing effective supervision and maintaining productive relationships with novices is time. Due to factors like the numbers of learners a clinical educator may be expected to work with, his/her patient load, and research expectations, the time allotted for conferencing with learners, engaging them in guided reflection, and designing individualized learning experiences may be compromised. Still, clinical educators must orchestrate ways to enact effective supervision within present time constraints. Kilminster and Jolly found that, when determining how effective supervision has been, the relationship
between supervisor and novice trumps things like the pedagogical methods used. There is a need, across professions, to study particular features of supervision—including the people doing the work—so that the work can henceforth be enacted on a solid empirical and theoretical basis rather than primarily on assumptions.

Proctor (2010) has conducted some important and often cited work on supervision. Though her work does not focus strictly on clinical supervision with novices (a gap in the medical education literature in this area has been noted) and gives attention to supervising experienced practitioners, it is still useful in thinking about clinical educators’ work with novice practitioners. Proctor’s model for supervision, the “supervision alliance model,” is cited as the most frequently used model for clinical supervision within the medical education context (p. 23). The model’s most important purpose, according to Proctor, is its “supportive function.” She writes, “Effective supervision requires a supportive underpinning as the foundation upon which the formative and normative aspects of supervision are built” (p. 23). Tension between the supportive and evaluative roles a supervisor plays have been documented in the teacher education literature (Copland, 2010; Feiman-Nemser, 2001a; Slick, 1997), but the ability to strike a balance between the different functions (Burns, 2012) of the multidimensional professional role is something practitioners must master. Proctor addresses the aforementioned tension common to supervision as its “restorative and normative tasks” (p. 26). That openness and trustworthiness are paramount components of productive supervisory relationships is stressed by Proctor’s work. Underscoring the many particulars associated with supervisory relationships (e.g. a particular supervisor working with a particular novice in a particular context), Proctor explains the importance of, early on, reaching agreement about each member’s particular expectations, a “supervisor’s methods of working in supervision, [and a] practitioner’s
developmental needs…learning goals, [and] preferred learning styles” (p. 25). Creating and maintaining open lines of communication about these significant matters can help create the trust needed for a supervisor and practitioner to have a relationship constructive toward professional learning and development. In Proctor’s words, “The process of discussing and establishing the alliance is the vehicle through which an intentional and unique relationship is initiated between this particular practitioner and this particular supervisor, in this particular context.” (p. 25).

One element of Proctor’s (2010) work germane to the present study is the attention she gives to reflection. She believes reflective practice is an essential aspect of professional practice that can indeed be taught. Proctor notes that clinical supervision can support growth in supervisors’ and practitioners’ reflexivity. She explains that learning from both one’s own practice and another’s experience (e.g. a novice practitioner learning from a clinical educator’s particular, relevant experience) make “clinical supervision…a uniquely formative process” (p. 25). Meanings made from clinical practice experiences, during guided reflection between novice practitioner and clinical educator, can be influential toward novices’ professional formation (Cooke, Irby, & O’Brien, 2010; Wear & Castellani, 2000). Guided reflection sometimes occurs during supervisory conferences. Aligned with teacher educators who advocate for student teachers having a voice in supervisory conferences (Borko & Mayfield, 1995; Valencia, Martin, Place, & Grossman, 2009; Veal & Rikard, 1998), and medical educators who believe in the importance of helping novices develop into self-assessing practitioners (Cooke, Irby, & O’Brien), Proctor believes it’s essential that supervisees are able to decide what particular area(s) of their practice (i.e. at a particular point in time) the supervisor should focus on when observing and offering feedback. These areas, then, can be further explored during guided reflection and meaning making. When the supervisor takes an authoritarian stance and makes all decisions
about supervision, the practitioner is not as likely to develop into a “self-directing” (p. 32) professional. Similar to findings from Irby’s (1994) work, Proctor believes that having experienced “good supervision” (p. 30) can be an important part of learning how to enact supervision effectively. Those familiar with Lortie’s (1975) apprenticeship of observation, and who believe it is not the way to prepare for the role of educator, may disagree with each Irby’s (1994) and Proctor’s stance. Undeniable, though, is that the practices and dispositions clinical educators model for novice practitioners, be they explicitly or not, have implications for novices’ professional formation. Those involved with clinical education must, like Proctor, recognize that learning to do clinical supervision is complex, time-consuming work with implications for the profession’s future. Along the same lines as some teacher and medical educators (Hammerness et al. 2005; Grossman et al., 2008; Steinert, 2014), she supports arming those learning how to do clinical supervision with frameworks they can call on when enacting the clinical educator role.

Skeff’s (1988) work, though written 26 years ago, points to the still pressing need to pay attention to clinical education in light of a healthcare system that continues expanding and gaining complexity. He contributes a “seven-component conceptual framework for analyzing the clinical teaching process and improving teaching effectiveness” (p. 526). After a decade of studying clinical teaching in different contexts, he and his colleagues found that novices’ learning was positively influenced when educators worked to improve the interconnected domains of the framework. The components are learning climate, control of the teaching session, communication of goals, understanding and retention, evaluation, feedback, and self-directed learning. Like others (Kilminster & Jolly, 2000), Skeff identifies time as an obstacle to teachers doing things like creating occasions to debrief with learners. Because components of the framework are interconnected, when one area receives insufficient attention because of factors
like limited time and the educator’s lack of preparedness to carry out a particular pedagogical approach, other areas of the framework are negatively impacted. As has been noted elsewhere, in order for important changes to occur in medical education—so that teaching and learning are positively impacted—teaching must be professionalized. Consequently, teachers may have access to needed, quality professional development and the time required to engage with learners in a number of teaching and learning experiences. One of the most important components of the proposed framework is self-directed learning. Defined as “an individual learner’s initiative to identify and act on his/her needs, with or without the assistance of others” (p. 530), it is the sort of learning that transcends the space of time known as GME and extends through a practitioner’s professional lifespan. When adequate time with learners and the capacity for both modeling and explicitly teaching about self-directed learning are absent, novices run the risk of entering independent professional practice without the habits of mind and action characteristic of self-directed learning. These habits align with an inquiry stance (Cochran-Smith & Lytle, 1999), reform mindedness (Feiman-Nemser, 2001a), and field building (Cooke, Irby, & O’Brien, 2010). Skeff believes, “A significant portion of the responsibility for the training of future physicians rests with clinical teachers. Therefore, efforts to improve their effectiveness must be supported” (p. 530). I agree with his stance and further believe the same holds true for clinical educators in teacher education. Using frameworks like the one proposed by Skeff, coupled with efforts to professionalize medical educators’ work, medical education may see improvements in both teaching and learning.

Neher, Gordon, Meyer, and Stevens (1992) underscore the time constraints faced by clinical medical educators. They further expound upon problems not alien to teaching’s clinical education. The group expresses that “clinical teaching skills are not innate...[and] untrained
clinical teachers tend to give mini-lectures rather than conduct discussions, provide inadequate feedback…and allow residents to…bluff their way through presentations” (p. 419). If professionalizing teaching and ensuring clinical educators are prepared for their role do not occur, the poor pedagogical practices documented in the literature will persist. This can be at least partly attributed to the “apprenticeship of observation” (Lortie, 1975). Building on Koen and Vivian’s (1980) (as ctd. in Neher et al.) work on clinical teaching, the authors created a model that can be learned and implemented quickly. Though I don’t suggest that effective clinical teaching can be learned in haste (e.g. by memorizing a list of observable behaviors), I believe their intention was to make a contribution to the field given current circumstances. Their model encompasses five microskills: (1) get a commitment (2) probe for supporting evidence (3) teach general rules (4) reinforce what was done right and, (5) correct mistakes. The model holds resonance with the present study because, throughout the teaching and learning encounter, the educator is not concerned with imposing meanings s/he’s already made onto the novice. Rather, the educator gains “access to both the constellation of facts that the resident uses in decision making and the decision-making process itself” (p. 420). Employing the five step microskills model positions clinical educators to be concerned with novices’ meaning making from clinical practice experiences. The model can also help educators build the sort of honest relationship needed in clinical practice experiences. The purpose of asking questions, for example, is to give learners a “low-risk way” to “[think] out loud” (p. 421) and not to pimp¹ them, as is common in medical education. Neher et al. acknowledge the complexity inherent in the relationship and interactions between clinical educators and novices. They do not suggest that their model

¹ Kost & Chen (2014) describe pimping in the medical education context as “more senior members of the medical team publicly asking questions of more junior members…. [I]t evokes negative emotions in learners and leads to an environment that is not conducive to adult learning. Medical educators may employ pimping as a pedagogic technique because of beliefs that it is a Socratic teaching method. Although problems with pimping have previously been identified, no alternative techniques for questioning in the clinical environment were suggested” (p. 1).
accounts for every variable a clinical educator should consider. Nevertheless, their model can provide guidance for clinical educators who are committed to the work but find themselves with limited professional development offerings and time to participate in them.

McGee and Irby (1997), focusing on clinical teaching in the outpatient clinic, are among other medical educators citing time as a barrier to achieving the most effective clinical teaching. In fact, they found that educators tend to have “one minute or less per case” (p. S34) with novice practitioners. The two note that, more than surface level features of clinical education (e.g. the kinds of cases a particular clinic sees), a teacher’s actions have more potential to shape the clinical practice experience. They write, “Effective teachers ask questions, show interest, define goals, demonstrate competence, and, most importantly, spend time with the learner” (p. S34). It serves mentioning that the gauge for effective teaching tends to come from students’ points of view. Though these can have merit and be accurate, they can also be misaligned with the aims of each particular academic courses and program content. The two contend that, especially in light of the identified power of role modeling, a pressing difficulty clinical educators must work to overcome is building “opportunity and space for meaningful dialogue with one or more learners in the midst of a busy…clinic…” (p. S34). Along the same vein as Neher et al. (1992), McGee and Irby provide clinical educators with suggestions that can, rather efficiently, be put to practical use when planning for and enacting teaching. In brief, the pair encourages doing the following: (a) being explicit with learners about the expectations tied to their role in the clinical setting, (b) thoughtfully using questioning as a way to “show interest in the learner’s thoughts, …encourage…clinical reasoning” (p. S35) and reveal learner’s thought processes so that choices can be made about how to tailor learning, (c) selecting an essential teaching point, (d) “priming” novices in preparation for patient encounters, (e) modeling professional practice for learners
through actions such as thinking aloud and sharing rationales, (f) making sure to also see novices’ patients, (g) giving learners specific feedback highlighting strong points in their developing practice as well as providing suggestions for improving areas in which proficiency isn’t evident, and (h) creating occasions for teaching after both specific patient encounters and the entire shift. Similar to the CT’s work, it’s essential the attending physician orchestrate “reflective conferences” (p. S38) and use them as a time for everyone to work toward understanding what was learned from specific clinical experiences. Through continued teaching experience and intentional efforts to reflect on teaching and learning experiences shared with novice practitioners, clinical educators will become more adept at pulling “teaching scripts” (S36) from their schema for particular learners and during particular clinical situations. Additionally, they will strengthen their ability to anticipate which problems of practice are likely to be most challenging for learners. Through implementing their suggestions, McGee and Irby believe teachers stand to make lasting and powerful impressions about exemplary professional behaviors—from using clinical reasoning for thinking through a case to demonstrating strong bedside manner with all patients. In clinical education, novices observe and learn from educators’ specific teaching methods as well as their actions and dispositions when enacting the role of physician.

Clinical teachers, whether themselves novice or experienced in their professional role, will be evaluated as a part of the academic position. For those on tenure and promotion tracks, evaluations—be they from students, other faculty, or administrators—carry weight. The Stanford Faculty Development Program (SFDP) continues studying what constitutes effective clinical teaching. Litzelman, Stratos, Marriot, and Skeff (1998) set out to validate the seven-category framework developed by SFPD and to see if it could be simplified. The framework, regularly
used for faculty member evaluation and for faculty members to assess and improve their own teaching, includes the following categories: (1) establishing a positive learning climate, (2) control of the teaching session, (3) communicating goals, (4) promoting understanding and retention, (5) evaluation, (6) feedback, and (7) promoting self-directed learning. An absence of professional development opportunities for clinical educators has been noted. The SFPD is one of the available and respected programs, and the aforementioned categories ground the program’s content. Identifying a need for rigorous quantitative studies offering validity to available educational frameworks, Litzelman et al. used factor analysis and a split sample of 1,581 medical students’ evaluations of their clinical teachers. One key finding from the study, which relates to the present study, is that effectiveness in clinical teaching isn’t marked by educators who transmit factual information to novices—particularly in situations marked by high degrees of uncertainty. Instead, as stated by the study’s authors, “an effective teacher-learner partnership” might be more accurately characterized by “providing an approach to learners’ questions that allows trainees to discover answers on their own” (p. 694). Such a pedagogical approach is essential because it helps promote the kind of self-directed learning characteristic of professionals committed to (a) interrogating both professional practice and scholarship and (b) building up both their own practice and the field (Cooke, Irby, & O’Brien, 2010). Further, a parallel between the novice classroom teacher (i.e. student teacher or induction stage teacher) and the novice clinical medical educator is the assumption that the teacher must have all of the answers and have them on the spot. Litzelman et al. explain how a focus on amassing all of the facts can be counterproductive to supporting self-directed learning. Hence their suggestion that faculty development programs explicitly teach about self-directed learning and how such an orientation can be instilled and strengthened in students. Effective clinical education is not
distinguished by transmission of the meanings a clinical educator has made from experiences in the professional practice context to his/her students. This study found that novices did not perceive clinical educators as not being knowledgeable because they did not have all the answers and chose to guide novices through activities promoting self-directed learning.

Irby’s (1994) work gives attention to an area left out of the SFPD framework. Though Litzelman et al’s. (1998) work found that educators’ content knowledge could be collapsed into the category of encouraging self-directed learning, not enough work existed to make clear the knowledge bases clinical teachers needed a strong command of in order to enact effective clinical teaching. Irby, working with six attendings who were identified as “distinguished,” revealed the following “domains of knowledge” as ones requisite for exemplary clinical teaching: case-based teaching, medicine, patients, learners, and general principles of teaching (p. 335). Effective clinical educators draw on these domains while simultaneously considering the particularities of their context. Irby’s work builds on work familiar to teacher educators; namely, the works of Grossman (1990), Lee Shulman (1986; 1987), and Lortie (1975). Through case study methodology and interviewing as a data collection technique, the author developed a model of clinical teachers’ knowledge. By calling on their pedagogical content knowledge (Shulman, 1989), clinical educators can make discipline specific knowledge “comprehensible to particular learners” (p. 334) and set themselves apart from non-educator disciplinary experts. The Holmes Group (1986), though not explicitly using the term pedagogical content knowledge, spoke to its essentiality in effectively carrying out the role of teacher. Providing an example from medicine, the Group wrote that “being a good student of anatomy and physiology [does not equate to] knowing how to perform surgery…. [A]nalytic knowledge of the subject is a necessary element in good surgery, but it is hardly the same thing as surgical skill” (p. 12). One
of Irby’s findings connected to the present study is that the most effective clinical educators develop knowledge of learners at a macro level (e.g. knowing that interns tend to ask “a” kinds of questions about “x” and third year residents tend to ask “b” kinds of questions about “x”), while also making a conscious effort to develop knowledge of individual learners. This is important because combining these two knowledge types is conducive to helping particular learners make meaning from particular clinical practice experiences. Moreover, the knowledge clinical educators build of particular learners is integral to their ability to develop appropriate evaluations and provide specific, useful feedback. Participants in the study, despite identification as “distinguished,” admittedly learned to teach from both the examples and non-examples of the clinical teaching they experienced through the “apprenticeship of observation” (Irby, p. 339; Lortie, 1975). In medicine, it appears the apprenticeship of observation is not seen as entirely problematic. Such is the case despite documentation that learning to teach through observation doesn’t allow novices to be privy to the teacher’s professionally oriented thinking and the knowledge bases informing his/her actions. Also surprising is that clinical educators who received no formal preparation for the role did not participate in much professional development—whether that be through reading relevant professional literature or attending appropriate workshops. Irby explains that the apprenticeship of observation and the “wisdom of practice” (p. 340) educators gain through lived experience can be helpful in bringing about a knowledge base sufficient for clinical teaching. He does suggest that “systematic teaching-improvement programs” (p. 340) can make the process of becoming a knowledgeable clinical educator more efficient. However, though I respect Irby’s work, I don’t believe the apprenticeship of observation is the education needed to become a professional clinical educator. It is past due time that programs dedicated to preparing clinical educators for their role, and
offering support and professional development opportunities as educators evolve in their role, are
developed.

The CT’s Role in Clinical Education

Just as varying facets of the clinical educator’s role have been studied in medicine, the cooperating teacher’s role has been studied in teacher education. The CT plays an important role in preservice teachers’ clinical practice experiences. One unfortunate cut-through in studies looking at teaching’s clinical practice experiences and the CT’s role is that there are too many untapped opportunities for preservice teachers to maximize learning and development (Borko & Mayfield, 1995; Valencia, Martin, Place, & Grossman, 2009). These untapped occasions for preservice teacher learning are sometimes related to conflicts among triad members and a lack of complete understanding about triad members’ roles and responsibilities.

Veal and Rikard (1998) studied the triad from the CT’s perspective. Using triad theory to guide their work, the authors analyzed interviews with 23 CTs. The two built on Barrows’ (as ctd. in Veal & Rikard, 1979) work, which pointed to the hierarchy present in triads. They note that tensions implicit to hierarchical relationships and apparent in student teaching triads may be amplified because of the lack of consensus surrounding each member’s role. Their study found that, despite having less decision making power than the US, CTs had more influence over STs. Of course, in ideal situations, the ST and the CT should spend ample time together engaged in things like lesson planning, reflection, and discussing feedback on the student teacher’s developing pedagogical practice. Veal and Rikard elucidate on the point that when USs make their infrequent appearances, “There is great potential for a relational disturbance” (p. 109). The pair’s study, which made use of a convenience sample of physical education teachers with at least six years of teaching experience, found two types of triads emerge during the course of the
student teaching experience: a functional and an institutional triad. In the former, CTs held the most power, followed by the ST and students, respectively. The latter places the US in the position of power, followed by the CT, the ST, and excluding the P-12 students. It’s evident that CTs alternate between triads and make modifications in behavior depending on the triad-in-action at any given moment. As related to the present study, the CT may make sense of his/her role in helping STs make meaning from clinical practice experiences differently depending on which triad is being enacted. If the US is present, for example, and both the US and CT are supposed to be active participants in guiding a ST’s meaning making, the CT may take a less participatory role and assume a role that protects the ST in the face of the US. In Veal and Rikard’s terms, “The CT attempts to save the ST from the unfair actions of the US who operates from a position in the ivory tower” (p. 112). Their work points to a lack of conceptual and structural coherence in teacher education. When there is no shared understanding of triad members’ roles and responsibilities, and no consistent, concerted effort to support novices’ learning and development, clinical practice experiences become marked by tension and missed occasions to make meanings from particular experiences; importantly, these are meanings that can prove useful and be further built on during the induction years and beyond. I agree with Veal and Rikard’s assertion that what is needed is collaboration among triad members. As they point out, many STs will likely go on to serve as CTs themselves; this is similar to the point that many medical residents will go on to serve as clinical faculty at some point in their careers. There are potential negative implications for how current STs (and medical residents) will go on to make sense of their role in helping novices make meaning from clinical practice experiences if they are passive participants in their student teaching triad due to tensions from its hierarchical nature. Additionally, similar to the lack of formal preparation for becoming a clinical educator in
medical education, there is little formal preparation for becoming a CT. Hence, as studied by Veal and Rikard (1996), many “rely heavily on their own ST experiences as preparation for becoming supervisors” (as ctd. in Veal & Rikard, 1998, pg. 116). In order to diminish triad tensions and support collaboration among all members, Veal and Rikard suggest that STs (a) have a voice in organizing triad conferences, (b) the opportunity to speak at length during conferences, and (c) “own the naming and framing of problem areas and strengths” (p. 117). I believe that the CT and US roles should be marked by intentionality toward helping STs develop the capacity to discuss, study, and act on problems of practice. If the CT (or US) regularly dominates a conference and imposes his/her own meanings on the majority of clinical practice experiences, novices aren’t likely to develop into inquiry oriented (Cochran-Smith & Lytle, 1999), field building (Cooke, Irby, & O’Brien, 2010) practitioners.

Valencia, Martin, Place, and Grossman (2009) document how triad members’ identity struggles, a lack of substantive teaching and learning conversations, and the minimal amount of feedback given to STs contributed to missed occasions for ST learning. Citing a need to study “the complex interactions of key triad members…[and] other forces that interact to create or constrain opportunities for preservice teachers to learn,” (p. 304) the group studied nine STs by implementing interviews and observations as data collection tools. Interviews and observations were conducted with CTs and USs as well. Activity theory framed their work, and it posits that individuals’ frameworks come to be from how they participate in and “problem solv[e] in” particular contexts (p. 306). Though activity theory doesn’t suit the present phenomenological study, considering how methods used to guide novices through problem solving in their particular student teaching contexts might inform their clinical reasoning does. Further, building on Veal and Rikard’s (1998) work, activity theory accounts for tensions present in particular
contexts. Related not only to activity theory but to a constructivist stance as well, the authors found that each triad member’s unique views about student teaching influenced how they conceptualized their role, the responsibilities associated with it, and how they communicated with each other. Valencia et al.’s findings align with some of what has been previously noted. For example, CTs in the study revealed that their methods for clinical teaching were derived from their own student teaching histories. Unfortunately, all CT participants reported their stance that STs learn to teach best when they observe more experienced teachers, try to emulate behaviors, and are left to teach on their own. This approach to clinical education runs counter to the sort of collaboration and shared triadic power championed by Veal and Rikard. To use Valencia et al.’s terms, CTs in the study supported “mimetic” and “benign neglect” approaches to student teaching. While the practice of having student teachers try out pedagogical methods they have observed their CTs enact is not an inherently bad one, STs must first be guided through the important cognitive task of unpacking/“decomposing” (Grossman et al., 2009) what they have seen the CT do. Decomposition of practice is an important type of meaning making in the clinical practice context and novices need assistance thinking through it; as I see it, such assistance is an important part of the CT’s role. Valencia et al. explain that post observation conferences are an ideal time for this significant, guided meaning making because they give STs access to CTs clinical reasoning and “locate conversations in the particulars of instruction” (p. 314). However, researchers observed that conversations between student teachers and cooperating teachers failed to address particulars of secondary ELA education and lacked focused feedback. As noted by Irby (1994), the ability to use Shulman’s (1986; 1987) pedagogical content knowledge during interactions with novices is a hallmark of effective clinical educators’ practice. Student teachers need CTs who are more than experts in the English
discipline; they need CTs who can help them better understand particular clinical practice experiences, in a particular secondary ELA classroom, through the lens of a secondary ELA classroom teacher. Aligned with Veal and Rikard’s work, Valencia et al. call for more than increased understanding of triad member roles; they believe gaining understanding of “the multiple roles each member plays,” (p. 318) the tensions innate to the interplay of those roles, and efforts aimed at ensuring that, considering those roles, all members are active participants in the triad, is essential.

Valencia et al.’s (2009) work echoed findings made by Borko and Mayfield (1995). Pulling data from a longitudinal study, the pair studied how university supervisors and cooperating teachers impact the student teacher’s learning to teach experience. Similar to the Valencia et al. study, the pair collected data by observing conferences between STs (N = 4) and CTs (N = 4) and interviewing participants. A troubling similarity between the two aforementioned studies is that STs missed out on learning to teach opportunities because CTs failed to engage them in necessary, regular, substantial conversations about the many teaching and learning complexities occurring during the clinical practice experience. Though CTs are reported to be influential in STs learning to teach experience, they fall short of realizing the full, positive influence they can have on novices’ development when they aren’t regularly intentional in engaging them in dialogue aimed at making meaning from clinical practice experiences. If student teaching is to serve as a powerful, productive portion of teacher education (Feiman-Nemser & Buchmann, 1987), STs can’t be left to fend for themselves. ST participants in Borko and Mayfield’s study had little confidence in their relationships with CTs: “They primarily wanted the opportunity to practice and to learn by doing…[and] hoped for some suggestions and feedback” (p. 515). This is the kind of learning to teach experience marked by the mimesis
Valencia et al. documented. Rather than learning from clinical practice experiences in ways that can prove useful in the future because CTs guide STs through meaning making, the lack of collaboration leaves novices on the periphery of learning. Holding relevance to how CTs make sense of their role in helping novices make meaning from clinical practice experiences, Borko and Mayfield found that CTs who felt “they could and should have an active role in the process of learning to teach” (p. 516) spent more time conferencing with STs and gave them the sort of substantial feedback needed for them to make progress in their unique learning to teach journey. Like previously cited medical educators (Hesketh et al., 2001; Proctor, 2010; Steinert, 2014), the authors believe that providing CTs with professional development for their role could help make them feel more confident in their ability to model practice, guide novices through reflective dialogue, and provide essential feedback.

Bullough and Draper (2004) call attention to the imprint that context, and individual personalities and histories, can leave on the CT/ST relationship. Focusing on a single student teaching triad, the pair met with CTs (referred to as mentors) a total of six times and discussed (a) mentoring research and (b) logs CTs maintained of their interactions with interns. Researchers also recorded conversations mentors had with one another and utilized research assistants to interview each CT individually. Their findings mirror others cited within this literature review. For instance, due to triad tensions (Veal & Rikard, 1998), STs mimicked (Valencia et al., 2009) what they observed CTs doing. Such mimicry can be borne of the ST’s want to prevent tension with the CT and the belief that s/he must please the CT because of his/her potential influence over future employment decisions. Mimicry was identified by the Holmes Group (1986) years earlier. They explained that most clinical practice experiences fail to challenge student teachers and, rather, encourage “imitation and subservience to the supervising
teacher” while also failing to advocate for “investigation, reflection, and solving novel problems” (p. 55). Similar findings about novices saying what they believe a particular faculty member or clinical educator will consider “right” are found in the medical literature (Yardley, Brosnan, & Richardson, 2013). Bullough and Draper’s work documented a triadic relationship ruled by complacency. When a ST and CT do not speak openly with one another on a regular basis, leaving important meaning making and feedback oriented conversations on the table, STs aren’t likely to realize their full potential and develop into reform-minded (Feiman-Nemser, 2001a), field building (Cooke, Irby, & O’Brien, 2010), practitioners. Like others (Valencia et al., 2009; Veal & Rikard, 1998), Bullough and Draper concur that preparation for the role of CT is needed so that clinical educators know how to navigate the complexities of the triad, “face the tacit and unrecognized models of professional development that they may hold” (p. 419), and nurture professional relationships with STs that simultaneously challenge and support them. These things must occur so that STs are on a trajectory to proficient independent practice, lifelong learning, and contributing to the field throughout the professional lifespan. The latter may occur through ST’s own service as a CT.

**Meaning Making**

The concept of meaning making is an important part of the present study. Whether altogether directly or not, meaning making has been studied in the medical education context. Hunter (1991) carried out a key study in this area. Exercising an ethnographic methodology, Hunter spent two years immersed in a GME setting observing features of surgery and internal medicine’s clinical education. She focused specifically on the “interaction between physicians teaching and learning to take care of patients…” (p. xiv). Given that a secondary ELA educator is a participant in the present study, my own background and present affiliation with English
education, and work done on meaning making with close ties to the English education context (Edge, 2011; Rosenblatt, 1995), it serves mentioning that Hunter paid particular attention to the use of “‘literary phenomena’” (p. xiv). Through her study, Hunter determined that narrative structures permeate both teaching and learning occasions, as well as the enactment of professional medical practice. In order to frame the teaching and learning occasions she observed (e.g. grand rounds), Hunter paid attention to the language exchanged during interactions that would help her address topics like knowledge acquisition, “the process of professionalization, [and] the effect of the academic hierarchy” (p. xiv). She came to determine the professional practice of medicine as one that is artistic, interpretive, and concerned with particulars. Considering each patient as a unique text, the practitioner must call on broad bodies of knowledge and interpret them in light of a patient’s unique case so that the best course of action can be ascertained and enacted. This sort of meaning making in the clinical practice context contributes to Hunter’s assertion that medical practice is an art and not “an invariant and predictive account of the physical world” (p. xviii). It is important to note Hunter’s point that because interpretive activities do not have a certain, obvious place in medical education they are not nullified as being central to physicians’ ways of knowing and doing.

Continuing with Hunter’s work, just as Dewey (1904) pointed out that focusing on culminating activities as an endpoint of teacher education could orient preservice teachers’ attention in the wrong direction, beginning in medical school and extending through professional practice, Hunter contends that a longstanding, narrow focus on medicine as strictly a science has been detrimental to each medical education and practice. Further, it orients physicians’ attention toward diagnosing patients rather than toward the entire constellation of variables that should be considered in making meaning of the “patient as text” (p. 340) and, most importantly, “the care
emphasis added] of the person who is ill” (p. xix). Hunter believes that in order to redirect attention from a microscopic focus on diagnosis to a focus that includes patient care, medicine must come to be known “as a narrative activity” (p. xxi). The shift, then, must occur in medical education contexts, including clinical education environments like teaching hospitals.

Irby’s (1994) work calls attention to Hunter’s study. Expounding on the importance of clinical educators and novices alike building conceptual teaching scripts, Irby identifies the meaning making both parties move through as essential to the script building process. Through the deliberate act of meaning making—helping novices connect meanings made from a particular patient’s presentation to both other cases and relevant bodies of knowledge—clinical educators assist novices in constructing conceptual scripts that can be called on during future attempts at practice while simultaneously refining their own conceptual frameworks for the practice of each teaching and medicine. Irby writes that through case based teaching, common in medicine’s clinical education, educators determine “both the patient’s illness and the learner’s representation of the case, and then [help] the learner make sense out of the experience” (p. 339). Meaning making from clinical practice experiences is most definitely a part of exemplary clinical educators’ repertoire. An issue might be that it is rarely explicitly addressed; and, that is coupled with a lack of professional development opportunities for clinical educators aiming to help them understand meaning making in the clinical education context and how to most thoughtfully guide novices through it.

Work done by Reichert, Solan, Timm, and Kalishman (2008) is laying groundwork to remedy this gap in medical education. In 2005, the group launched a pilot study (N = 9) that has seen growth in voluntary participants each year. By 2008, there were 60 medical student participants and 58 mentor participants. Participants were part of an eight-week clinical
experience known as the Practical Immersion Experience (PIE). During the PIE, students see patients with their mentor and participate in both a community service project and a sequence of lectures for which they set the pace. Noting an upswing in current medical literature demonstrating interest in reflective writing and its potential benefits for novices, the group decided to add a Narrative Strand to the PIE. They aimed for the reflective writing component to help students “discover and examine the ways they made meaning of their new experiences in the field” (p. 230). Reichert et al. share that reflective writing within the medical education context has been shown to facilitate students’ development of “self-awareness…empathy…and the ability to] integrate the personal with the professional to enhance patient care” (p. 248).

Mentors did not grade students’ writing but did respond to it. The written exchange between mentor and novice served as a form of professional development for both. Students’ writing demonstrated their struggles with professional identity and values. Some students reported that creating the time for writing was challenging. Overall, however, they found the Narrative Strand productive toward making meaning of clinical practice experiences, their professional role, and broader medical topics. Beyond helping students’ developing practice, the experience proved valuable for mentors’ reflective and mindful practice.

Yardley, Brosnan, and Richardson’s (2013) work also looked at medical students immersed in Authentic Early Experiences. Through interviewing students (N = 23), supervisors (N = 20), and faculty (N = 13), authors gained some insight into how novices construct knowledge and make meaning in the clinical practice setting. They write, “[L]ittle is known about how or why meaning and knowledge are constructed through early student placements in medical…workplaces” (p. 109). The group found that, despite the goals assigned to a particular AEE, there were “unintended consequences” (p. 112) as a result of how students made meaning.
from the experiences. For example, students made meaning from experiences under the assumption that becoming and being a professional practitioner meant abandoning their “lay and personal perspectives” (p. 113). Though it’s true that a professional may need to set aside certain personal beliefs as s/he enacts the professional role and works through a particular problem of practice, it’s important that novices confront the personal and lay perspectives they bring to AEE with guidance from clinical educators. In this way, novices are better positioned to understand whether or not a personal belief/experience may enrich a particular patient interaction and why a layperson perspective of working through a particular patient encounter is not wholly effective. It is critical to understand more about novices’ meaning making during clinical practice experiences because, as Yardley, Brosnan, and Richardson found, the meanings made have the potential to influence future professional practice.

**Rosenblatt’s Transactional Theory**

English and teacher educators have conducted important work on meaning making. Rosenblatt (1995), who is well known for her transactional theory, piloted some of the most influential work. Influenced by Dewey, Rosenblatt chose the terms *transaction* and *transactional* “to emphasize the essentiality of both reader and text” (p. xvi). The meaning making process, in Rosenblatt’s view—one I share—is not mechanistic and acknowledges a back and forth between reader and text. Aligned with a “post-Einsteinian view of science as an interpretive endeavor” (p. xviii), Rosenblatt’s work advances art and science as complementary. This aligns with aforementioned arguments made by Hunter (1991). Her work, as well as Edge’s (2011), also aligns with beliefs put forth by the Holmes Group (1986). Though they used the term “interactive” (p. 29), the Group commented on the ongoing exchange between a teacher and the learners in the dynamic classroom space. In the Group’s view, “competent teachers” develop the ability to read
and be responsive to the classroom space through “academic and clinical learning that prepares one to manage both mastery of content and the complex social relations of the classroom in a way that fosters student learning as well as an attachment to learning” (p. 29).

Rosenblatt’s (1995) transactional theory and the meaning making process she advanced hold resonance with the present study. Building on the works of Rosenblatt and Edge (2011), the student/reader can be conceptualized as the novice-practitioner mentioned throughout this study. Just as Rosenblatt believed students had to be taught to “revise or broaden” their assumptions, I believe clinical educators must take an active role in novices’ meaning making from clinical practice experiences so that their assumptions don’t persist, are questioned, and they “become aware of alternative possibilities” (p. 12). Rosenblatt wrote, “Like the beginning reader, the adolescent needs to encounter literature for which he possesses the intellectual, emotional, and experiential equipment” (p. 26). Though student teachers and resident doctors are not adolescents, and are likely at a different phase of emotional development than adolescents, they don’t necessarily have the “experiential equipment” needed to make meaning from clinical practice experiences in ways that will prove useful during independent professional practice. This is attributable to their limited experiences in the professional practice context. If novices are left to make sense of observations and interactions without guidance from more knowing others (e.g. cooperating teachers; attending physicians), it may be that there are “unintended consequences” (Yardley, Brosnan, & Richardson, 2013) of clinical practice experiences. Moreover, meanings made may be propelled by entering beliefs, assumptions, and stereotypical views of particular student/patient populations. If novices are to enter independent professional practice as reform-minded (Feiman-Nemser, 2001a) professionals who thoughtfully resist the status quo, it’s essential clinical educators participate in their meaning making and don’t allow clinical practice
to be a sink or swim experience.

Further, as articulated in both teacher and medical education scholarship, clinical educators must organize experiences for novices that demonstrate their understanding of novices’ individual stage of development. Expounding on her theory, Rosenblatt (1995) shared how teachers must select texts for students that demonstrate they have thought about linkages between the students and the material. Along the same vein, clinical educators must demonstrate they have thought about particular novices’ readiness for practice, the particular clinical practice context and its constituent attributes, and, then, the particular professional practices the novice should try out and reflect on. Irby’s (1994) work underscored the significance of clinical educators getting to know individual novice practitioners so that specific clinical experiences, dialogue, and assessments are designed accordingly. This, too, aligns with Rosenblatt’s work. She noted how classroom teachers need to understand things like why one student’s reaction might differ from other students’, why a student ignored certain elements of a text, and what in a student’s state of mind may have led to a distorted view of a particular text (p. 75). Rosenblatt expressed, “The reading of a particular work at a particular moment by a particular reader will be a highly complex process” (p. 75). Correspondingly, and aligned with Edge’s (2011) Classroom Literacy framework, clinical education is a complex process of which meaning making is an important and complex aspect. Conceiving of the classroom in which clinical practice experiences occur as a text and novice practitioners as some of its readers, it’s key clinical educators understand their role in structuring opportunities for guided reflection so that novices are better positioned to revise previous judgments (Rosenblatt). Situating clinical practice within Edge’s framework, the following of Rosenblatt’s points is pertinent:

The young reader needs to learn how to suspend judgment, to be self-critical, to develop and revise his interpretation as he reads…yet the techniques of the usual English
classroom tend to hurry past this process of active creation and re-creation of the text. The pupil is, instead, rushed into peripheral concerns. (p. 271)

With clinical educators’ guidance during clinical practice experiences and concurrent occasions for meaning making, novices can learn how to (a) engage in professional practice without letting assumptions guide their actions, (b) regularly self-assess, seek guidance, and make modifications as necessary, and (c) focus on substantive problems of practice rather than “peripheral concerns.”

**Edge’s Classroom Literacy Framework**

Clearly, Edge’s (2011) work on meaning making is important to the present study. Edge’s Classroom Literacy framework partially hinges on Rosenblatt’s (1995) conception of meaning. Specifically, “meaning is not an object or even an idea; it is a doing, a making, an event” (p. 53). This has bearing on the present study because, aligned with Rosenblatt and Edge, I don’t believe clinical education is about the novice (i.e. “reader”) extrapolating ready made meaning from either the clinical educator or the classroom space/clinical practice context as text. Rather, clinical educators must understand their role in guiding novices’ meaning making and must create regular occasions for the two to work through meaning making together. Both voices are an essential part of the process—the event. Given how Edge built on Rosenblatt’s theory for her own, which considers the classroom a dynamic text in transaction with practitioners, her framework can contribute to understanding how meaning making is conceptualized for this study. Both authors draw attention to the following, which is pertinent given the present study’s purpose: “Transaction has implications for all aspects of life…[it] applies to individuals’ relations to one another, whether we think of them in the…classroom, the school or in the broader society…” (Rosenblatt, as qtd. in Edge, p. 59). This study is concerned with describing how clinical educators make sense of their role helping novices make meaning from clinical practice experiences. Implicitly, then, it is concerned with clinical educators and novices relation
to one another; specifically, when these relations (i.e. transactions) are focused on helping novices engage in meaning making events so that they have new understandings of their transactions with particulars of the clinical practice context (e.g. particular students; a particular class).

Regarding her Classroom Literacy theoretical framework, Edge (2011) writes, “Extending Rosenblatt’s transactional theory to the context of teaching provides teachers, teacher educators, and researchers with a ‘window’ into teachers’ processes for making meaning” (p. 76). As I see it, Edge’s framework, though not serving as the theoretical framework for this study, provides a useful way for thinking about meaning making as meaning making is conceived of in this study. Specifically, it aligns with how I as a researcher think about the classroom space (clinical practice context as a whole) and the actors (i.e. readers) within it. I believe it also aligns with Crotty’s (1998) view of intentionality within phenomenology. Crotty writes, “What intentionality brings to the fore is interaction between subject and object…humans engaging with their human world. It is in and out of this interplay that meaning is born” (p. 45). Though the classroom literacy framework will not guide this study’s data analysis, it’s definition of meaning making does inform the study and I believe clinical educators from each the medical and teaching professions can implement the framework to get a “window” into their own as well their novice practitioners’ meaning making processes. Meaning making processes, and the meanings made, are important to understand so that both veteran and novice practitioners can further develop as professionals.
Conceptual Framework: Professional Formation

Professional formation (Cooke, Irby, & O’Brien, 2010; Wear and Castellani, 2000), which is at the core of professional education, serves as the study’s conceptual framework. Specifically, Cooke, Irby, and O’Brien’s, who build on Wear and Castellani’s, conceptualization of the construct. The former articulate how professional formation is a practitioner’s intentional, ongoing effort to achieve “excellence across the domains of practice” (p. 38) so that conditions of the populations served are improved. The latter explain professional formation as “an ongoing, self-reflective process involving habits of thought, feeling, and acting” (p. 603).

Professional formation extends throughout the professional lifespan. Those involved in professional education, whether they are clinical educators or professional school administrators, must ensure that the pedagogies of professional education (e.g. authentic clinical practice) are anchored by an understanding of professional formation and enacted in ways helping advance it.

In light of the stance that professional formation is at the core of professional education, and that we know too little about how professional educators (cooperating teachers and attending physicians) make sense of their role in helping novice practitioners make meaning from authentic clinical practice, professional formation serves as the conceptual framework for the study because the descriptions I will share in the study’s findings may help illuminate whether or not dimensions of professional formation informed how clinical educators made sense of their role (i.e. as related to the study’s purpose).

Aligned with the professional formation construct presented here, Bok (2013) points to four tasks every professional school is charged with. The two pertinent to the present study’s conceptual framework are (a) “instill[ing] a special mental discipline, a particular form of analytic thinking about the characteristic problems of the profession…. [A] ‘clinical habit of
“mind”” (p. 252) and, (b) “imbue[ing]…students with the ethical standards and professional responsibilities that practitioners need to observe in carrying out their work” (p. 254). Bok asserts that these unique habits of mind and subsequent action are the very things that “set true professionals apart…[,] help to earn the public’s trust and justify the faith that laypersons place in their expert judgment” (p. 254). If clinical educators in teaching and medicine don’t see it as a part of their role to make the profession’s unique habits of mind and action explicit to novices (e.g. how these habits inform meaning making from professional practice experiences), why couldn’t a layperson carry out the clinical educator’s work? If clinical practice experiences and the meanings made with the guidance of more-knowing-professional-others during those experiences are to play a productive role in novices’ professional formation, it can be argued that clinical educators should consider professional formation a function (Burns, 2012) of their clinical educator role.

Provided that clinical practice experiences are to be productive in the formation of “true professionals” (Bok, 2013), a point made by The British General Medical Council (2002) in its report *Tomorrow’s Doctors* is worth considering. They hold that the clinical teacher’s example “is the most powerful influence upon the standards and conduct of the trainee” (as qtd. in, Ramani & Leinster, 2008, p. 359). Ramani and Leinster underscore that a significant aspect of the clinical educator’s role “is the development of the professional role in students” (p. 358). As related to the present study and its conceptual framework, it’s crucial to the improvement of each teaching’s and medicine’s clinical practice experiences that we sharpen our understanding of how clinical educators make sense of their role in helping novice practitioners make meaning from clinical practice experiences. As such, educational leaders and reformers from each profession can stand better positioned to offer the particular kinds of training and ongoing
professional development opportunities that will help ensure clinical educators understand (a) the power their role modeling has on novices and (b) how to use their unique role to impress the profession’s particular habits of mind and action onto novices. Swanwick (2014) poses the question, “what do we mean by a professional in the 21st century?” (p. 5). If we don’t have a more clear understanding of this, how can clinical educators help shape future professionals and how can professionals across varying stages of the professional lifespan continuum help build the professional field?

A present fault line in teacher and medical education is a lack of understanding about how clinical educators make sense of their role in helping novice practitioners make meaning from clinical practice experiences (Cooke, Irby, & O’Brien, 2010; Harden & Crosby, 2000; NCATE Report of the Blue Ribbon Panel on Clinical Preparation and Partnerships for Improved Student Learning, 2010; Steinert, 2014; Wilson, Floden & Ferrini-Mundy, 2001). A heavy focus on surface level features (e.g. extending the amount of time novices spend in the clinical practice context) has led to a breakdown of conceptual and structural coherence (Ball & Cohen, 1999; Darling-Hammond & McDonald, 2000; Feiman-Nemser, 2001a). When conceptual and structural coherence exist, professional educators are better situated to ensure that pedagogies like experiential learning support the development of what lies at the core of professional education: professional formation (Cooke, Irby, & O’Brien; McGee & Irby, 1997). Focusing on surface level features, at the expense of fundamental ones, can prove damaging. If, for example, novices spend ample time immersed in clinical practice experiences, but do so alongside clinical educators who are complacent and advance the status quo rather than contribute to the field (Cooke, Irby, & O’Brien), the meanings novices make from those experiences may detrimentally
inform how they go on to “practice the practice” (Schon, 1987; Yardley, Brosnan, & Richardson, 2013).

Gaining clarity on how clinical educators make sense of *their* role in helping novice practitioners make meaning from clinical practice experiences can help both professions continue the important work of improving clinical practice. Such clarity can assist in reaching understanding about how to best ensure that clinical educators help novices develop the habits of mind and action needed for professional formation to occur across the professional lifespan. Such habits include an inquiry stance toward practice (Cochran-Smith & Lytle, 1999) and contributions to building the profession (Cooke, Irby, & O’Brien, 2010; Turner et al., 2012) by “transforming [practice] into scholarship” (Turner et al., p. 363). Sustainable change can be realized if, as underscored by Feiman-Nemser (2001a), there is a “productive joining of forces” (emphasis added) among those involved in clinical practice experiences. Such strengthening of conceptual and structural coherence (Grossman et al., 2008) can contribute to mending existing fault lines in clinical education.

![Figure 2.1: Features of Authentic Clinical Practice Experiences](image)

**Figure 2.1: Features of Authentic Clinical Practice Experiences**
Chapter Summary

The preceding chapter delineated findings from studies focused on aspects of teaching’s and medicine’s clinical practice that are relevant to the present study. A review of the literature made it clear that despite the importance of clinical practice in each profession it remains a largely understudied aspect of the professional education process. As such, many of the choices made in the clinical practice context are rooted in assumptions and/or are a conscious act to select the path of least resistance. Such decisions, on clinical educators’ part, have implications for how novices’ professional formation is shaped and the habits of each mind and action with which they enter independent, professional practice.

Evident in the literature is the lack of understanding, in teacher and medical education, about the clinical educator’s role. There is even a lack of consensus on the language used to discuss varying aspects of clinical education and the clinical educator role specifically. For example, there is no agreement on whether the clinical educator fluctuates through a number of roles stemming from the clinical educator role or if s/he carries out a series of functions associated with the role. In both professions, the lack of a codified body of knowledge has some negative ramifications for clinical education. To illustrate, the lack of codification prevents the development of professional development programs to (a) prepare clinical educators for the role and (b) support them as they grow in the role. Though several frameworks have been developed, some in an attempt to demystify the role and others with application purposes for those enacting it, the literature makes clear that work remains to be done.

Meaning making, a significant part of the present study, was also discussed. Literature revealed that meaning making has been studied in both the teacher and medical education contexts. It was found that the meanings novices make during clinical practice experiences do
have consequences for how they enter professional practice. Also explained was how both clinical educators and novice practitioners engage in meaning making during clinical practice experiences, which sometimes entails their drawing on previous experiences. Rosenblatt (1995) and Edge’s (2011) theories are key to how meaning making is conceptualized in the present study. Their work on meaning making as a transactional event, occurring in a dynamic context with particular “readers,” was detailed. Meaning making, whether occurring in an individual’s mind, during a conference between a clinical educator and novice practitioner, or through reflective writing, is an important part of clinical education and of the learning to “practice the practice” (Schon, 1987) process.

Despite the use of various search terms, no studies comparing the two professions’ clinical practice experiences were found. In spite of each profession’s interest to learn from the other, this remains a gap in the literature. If learning from the other profession is to occur, and the goal is to thoughtfully use findings to make needed revisions in how particular features of clinical practice experiences are conceptualized and enacted, studies like this one must take place. Of course, large-scale studies are needed.

Following, chapter three will detail the present study’s methodology. It will be clear that an interpretivist perspective and a constructivist epistemological stance guide the study. In-depth phenomenological interviewing, the selected methodology, will be explained so that readers understand how it aligns with all facets of the study. This includes how participants were selected and data each collected, analyzed, and presented.
CHAPTER THREE: RESEARCH METHODS

The previous chapter oriented readers to scholarship helpful in understanding the role of the clinical educator in each teacher and medical education. Further, work on meaning making, in both contexts, was detailed. The present study is concerned with gleaning understanding of the ways clinical educators make sense of their role in helping novice practitioners make meaning from clinical practice experiences. This chapter will make clear how in-depth phenomenological interviewing is an appropriate research method for studying and describing participants’ experiences with the phenomenon. It will be apparent how alignment exists among the study’s rationale, research questions, and all facets of the research methodology. Also evident will be how the theoretical perspective and epistemological stance correspond with the research design and its constituent parts.

Theoretical Perspective: Interpretivism

Crotty (2010) explains a theoretical perspective as “a way of looking at the world and making sense of it” (p. 8). An interpretivist perspective guides the present study. Meaning, interpretivism is the “philosophical stance” underlying in-depth phenomenological interviewing as the study’s methodology (Crotty, p. 66). The theoretical perspective also helps illuminate the assumptions I as researcher bring to the study. An interpretivist perspective is inherently interested in how people use language to communicate about lived experiences and make meaning as a way to “deal with” those experiences (Crotty, p. 66). Given the study’s aim of describing how professional educators make sense of their role in helping novice practitioners make meaning from clinical practice experiences, coupled with the belief that language is a key
component of such meaning making, an interpretivist perspective is appropriate for the study. Likewise, Bochner (2005) explains that interpretivist social science research is interested in how language can both give meaning to and incite “change [in] the world” (p. 66).

**Epistemological Stance: Constructivist**

Crotty (2010) explains epistemology as dealing with “*how we know what we know*” (p. 8).

This study is grounded in a constructivist epistemological stance. Lincoln (2005) writes that constructivists are interested in understanding meaning making processes undertaken by individuals so that they can “*enact* organization...co-create shared knowledge...and...construct meaning...” (p. 61). Those undertakings are well aligned with this study’s purpose and each research question and methods. Crotty further defines the constructivist epistemological stance by writing, “Truth, or meaning, comes into existence in and out of our engagement with the realities in our world” (p. 8). In light of the study’s aim to describe how professional educators make sense of their role in helping novice practitioners make meaning *from* clinical practice experiences, and the belief that clinical educators and novices must be engaged in the dynamic teaching and learning processes they share and undertake, a constructivist stance suits the study. Looking through a constructivist epistemological frame, the meanings novice practitioners make from clinical practice experiences will play a part in shaping their future attempts at enacting the multidimensional professional role of teacher and the attitudes they have about the role. Looking more deeply through the constructivist epistemological frame, these actions and attitudes will become evident in the contexts (Paul, 2005) at which novices go on to “practice the practice” (Schon, 1987).
Ontology: The Importance of Language

Regarding ontology, Crotty (2010) indicates that it “is the study of being…[and] concerned with ‘what is’” (p. 10). van Manen (1984) sees phenomenological research as work calling us to use language as a tool for discovering “what lies at the ontological core of our being” (p. 39). The present study will use language, throughout the series of interviews, as the primary tool for helping participants articulate their relevant lived experiences and get at the core of how they perceive their role in helping novices make meaning from clinical practice experiences. Within the context of a phenomenological study, van Manen describes using language to get at this ontological core as a “poetizing activity” (p. 39). Meaning, what is ultimately shared in the study’s findings, which should reveal features of participants’ ontological core, can neither be represented nor understood separate from the means employed to get there. For the present study, the means will be a series of in-depth phenomenological interviews. Through the language borne from poetizing we can “find ‘memories’ which paradoxically we never thought or felt before” (van Manen, p. 39).

Research Design

The present study’s purpose was to describe how professional educators (i.e. cooperating teachers and attending physicians) make sense of their role in helping novice practitioners make meaning from authentic clinical practice. It was guided by the following question:

In what ways do professional educators (cooperating teachers and attending doctors) make sense of their role in helping novice practitioners make meaning from authentic clinical practice?

A qualitative research design, in-depth phenomenological interviewing specifically, was appropriate for the present study. Such was the case because of the study’s aim to deeply
understand and describe a small number of participants’ (i.e. two) experiences with a particular phenomenon, in their particular contexts, at particular points in time.

**Research Methodology**

Seidman’s (2013) approach to in-depth phenomenological interviewing is congruous with the present study. The research method accentuates the place of making meaning of lived experiences so that lived experiences can be improved. This study sought to describe how clinical educators make sense of their role in helping novices make meaning from clinical practice experiences. I hope that participants’ future efforts to help novices make meaning from clinical practice experiences are enriched because of their participation (e.g. storytelling, reflection) in the study. I hope the individual meanings participants made prove productive and educative for their professional practice. This aligns with van Manen’s (1984) assertion that phenomenology’s primary goal is to help us “become more fully who we are” (p. 38). Perhaps, then, through having participated in the study, participants can become “more fully” who they are as clinical educators who regularly enact a complex, multifaceted role. Participating in the study provided spaces of time dedicated to intentional thinking and talking about their professional role, enabling them to see how individual components of their role contribute to and interact with the whole.

van Manen’s (1984) view of phenomenology as an “intentional thoughtfulness” (p. 38) to the particulars of one’s life and practice as an educator is woven through the present study. Through the series of in-depth phenomenological interviews, I guided participants through questions aimed at uncovering particulars of their practice as clinical educators. More precisely, particulars of practice related to the ways they make sense of their role in helping novices make meaning from clinical practice experiences. For myself, in my roles as each a teacher educator...
and an educational researcher, I believe intentionality in habits of mind is key. The habits of mind I am intentional about developing, in both roles, inform how I enact those roles and, hence, my interactions with novice practitioners (i.e. preservice teachers) and study participants. My “intentional thoughtfulness” to particulars, then, has implications for novices’ developing professional attitudes and practice and the stories participants were willing to share with me as I tried to co-create meaning with them. The latter aligns with a stance shared by Seidman (2013) and van Manen: ultimately, the study’s findings cannot be understood separate from the means (i.e. in-depth phenomenological interviews) employed to reach them. Explaining phenomenology as, “in itself, a simple enough concept” (p. 78), Crotty (2010) also places intentionality at phenomenology’s core. This intentionality means that we, as human beings interested in particular phenomena that are a part of our world, make a concentrated choice and effort to set out to more deeply understand—understand anew—particular phenomena. Flowing from intentionality in thought, van Manen, aligned with Cochran-Smith and Lytle’s (1999) inquiry stance, explains that within the context of educational research phenomenology ought to incite action. I share his view that, beyond acting responsibly in our professional educator-researcher role, we must act “responsively” (p. 38) to the insights we glean from phenomenology. Though this is a single, small study, I believe findings prove useful for participants’ continued work in clinical education, my plans to further pursue this line of research, and for other researchers invested in studying clinical education.

Regarding sample size, Hycner’s (1985) point is fitting. He explains that even though findings from a phenomenological study may not be generalizable because of the small sample size called for by the methodology, they are not inherently “useless” and have the potential to “be phenomenologically informative about human beings in general” (p. 295). Given the present
study’s involvement with the medical education context, a field that has traditionally favored quantitative/experimental methods, it is important to underscore that the study’s findings, though not generalizable beyond the study’s immediate contexts, at least helped participants understand some aspect of their reflected on, lived experience anew. Noting how the medical field has made much progress through the regular application of quantitative methods, Rivka Galchen also expresses that “sometimes the medical field makes the mistake of valuing most what is most easily measured” (as qtd. in Rosenbaum, 2013, para.12). Sharing her belief that medical education is presently “suffering,” she goes on to state that “the most important things to quantify are hard to measure: outcomes relating to quality and education” (para. 14). Creswell (2007) does note that phenomenology is a qualitative method with prevalence in health sciences and education; but, many of these studies have been carried out in health professions like nursing. This qualitative inquiry, despite its small scope, helps fill a void in medical education research by making participants’ voices a cornerstone. Seidman (2013) believes that, despite the copious educational research carried out in the United States, little of it seeks to understand particular issues—specific phenomena—through those who enact the work (e.g. cooperating teachers). To be sure, the methodology selected for a study should flow from the research question(s) (Mayan, 2009). But, Seidman’s point about the place of in-depth interviewing as a method of qualitative inquiry serves mentioning: “If the researcher’s goal…is to understand the meaning people involved in education make of their experience, then interviewing provides a necessary, if not always completely sufficient, avenue of inquiry” (p. 10). Through the rich descriptions made possible by phenomenological interviewing, this study provides both the medical and teacher education fields with an in-depth look at two clinical educators. The clinical educator role makes up a facet of clinical education in need of additional understanding.
A Closer Look at In-Depth Phenomenological Interviewing

The present study aimed to provide descriptions of the ways clinical educators make sense of their role helping novice practitioners make meaning from clinical practice experiences. As such, it was fitting to use Seidman’s (2013) approach to phenomenological interviewing because the in-depth interviews focused on participants’ stories while I worked to collect their experiences that related to the research question. Seidman explains storytelling as a process that, through detail selection, sequencing, and reflection, enables the teller to make meaning. According to Seidman, it “is an interest in understanding the lived experience of other people and the meaning they make of that experience” that drive in-depth interviewing (p. 9). He further notes that this back and forth, an ongoing questioning and answering between people, is the original method of human subjects inquiry. When participants work to reconstruct their lived experiences through reflection and telling, they create and articulate the phenomena (Schutz, 1967, as ctd. in Seidman). Through the reflective process of telling, prompted by the interviewer’s questions, the phenomena can come to be a repository of meaning for both the participant and interviewer. Acknowledging that complete objectivity is not possible, Seidman’s description of the purpose of “in-depth, phenomenologically based interviewing” (p. 14) follows: coming “as close as possible to understanding the true ‘is’ of…participants’ experience from their subjective point of view” (p. 17).

Seidman (2013) views in-depth phenomenological interviewing as “both a research methodology and a social relationship that must be nurtured, sustained, and then ended gracefully” (p. 97). Related to his stance, van Manen’s (1984) view that, more than a set of techniques and procedures, phenomenology is “a carefully cultivated thoughtfulness” (p. 67), resonates with me on both a personal and professional level. I believe this thoughtfulness is one I
am attentive to in casual and professionally oriented conversations. I believe my intentionality in demonstrating thoughtfulness to the multiple facets of interpersonal communication helped me in my role as researcher. For, I tended to language’s influence on relationship building and, ultimately, how to best use language so that participants’ lived experiences came to be arranged and represented in ways allowing verisimilitude. Phenomenology is a way of being for me. Keen (as qtd. in Hycner, 1985), echoes van Manen’s position that phenomenology is not a strict set of procedures but, much more, “an approach, an attitude, an investigative posture with a certain set of goals” (p. 279). Considering the present study’s aim, my professional lived experiences demonstrating my phenomenological “attitude,” and scholarship anchoring this study that underscores the importance of helping novices develop an “investigative posture” toward professional practice, I remain confident in-depth phenomenological interviewing was well suited for the study.

In-depth phenomenological interviewing necessarily involves a great deal of talk, and most talking ought to come from participants. It was essential for me, as the interviewer-researcher, to hone my listening skills. Seidman (2013) identifies three levels of listening that researchers must tend to: (1) understanding the details participants share so that they can decide whether or not they are thorough enough and subsequently use them to inform additional questions; (2) being attune to “inner voice” (Steiner, 1978, as qtd. in Seidman, p. 81), as this allows the interviewer to better decipher whether a participant is speaking in a more guarded, public voice or allowing him/herself to be open and vulnerable; and, (3) being thoughtful about factors beyond participants’ spoken words. For example, being mindful of the time, participants’ body language, and how the interview is progressing so that choices can be made about how to
make needed adaptations and move forward. I remained attentive to these things as the series of interviews unfolded.

**Participants & Contexts**

To begin, Seidman (2013) supports using the term “participants” (e.g. instead of a term like “interviewee”) because it helps underscore that the process of sharing one’s experiences is an active one. During the series of interviews, participants are not passively giving information and answering questions. In order to secure two participants, I used criterion sampling. Patton (1990) describes this sampling strategy as one grounded in the logic that “all cases…meet some predetermined criterion of importance” (p. 176). Noting the importance of criterion sampling in a phenomenological study, Creswell (2007) explains that it is key all participants have experienced the phenomenon. One teacher educator/cooperating teacher and one medical educator/attending physician made up the study’s participants.

In an effort to account for differences in the pathways to professional practice in each field, and the role of clinical educator more specifically, criteria for selection differed slightly between the teacher and medical educator. For example, the medical educator/attending physician spent a number of more years than the teacher educator/cooperating teacher in post-baccalaureate training because it was a requirement before he could practice. Considering that the medical educator spent at least three years engaged in graduate medical education (i.e. residency), and trying to have participants be somewhat similar in the number of years they are removed from baccalaureate and post-baccalaureate work, there were differences in selection criteria when it came to the number of years they have been independent, professional practitioners. The teacher educator needed to have at least ten years of classroom teaching experience in the secondary English Language Arts classroom. Important to note is that in the
school district from which the CT was drawn, she needed to have three years of classroom teaching experience before she was able to serve as a CT. Meaning, the CT needed to have seven years of experience as a clinical educator. She also needed to have ongoing experience as a cooperating teacher; meaning, there could not be a large gap of time (i.e. several years) between the times she served as a cooperating teacher. Ideally, the CT would have served as a CT for at least seven consecutive academic years. If that was not the case for a potential participant, the next choice was that s/he not have more than one academic year between service as a CT. The medical, clinical educator needed to have at least five years of independent, professional practice in the academic hospital setting. This means that medical educator needed to have five years of professional practice and clinical educator experience. Seidman (2013) suggests ensuring some commonality in participants’ “structural and social conditions” (p. 59). To help establish some parallels between participants, the teacher-clinical-educator needed be a National Board Certified Teacher and the attending-clinical-educator needed to be board certified in his/her specialty of practice. Also, the attending physician needed to be a core faculty member; meaning, having both direct involvement with residents and specific teaching responsibilities. One considerable difference between the teacher and medical clinical educator is that the cooperating teacher works with one student teacher at a time. The medical clinical educator, on the other hand, may closely mentor two or more residents at a time and can work with a number of residents during each shift. Also, though residents may have one, formal mentor (i.e. the medical-clinical-educator they most closely work with and receive guidance from), they engage in teaching and learning sessions with other attending physicians because they complete shifts with other attending physicians. This differs from the teacher education context because student teachers
are predominantly placed with one cooperating teacher and spend each school day teaching alongside/in the classroom of that CT. 

There are a couple of important considerations with the sample: the number of participants selected should (a) be sufficient for readers to be able to connect their experiences to participants’ and, (b) enable attaining saturation. Considering the study’s purpose and sample, it is also important to acknowledge the situated nature of teaching and learning; participants’ lived experiences cannot be understood separate from sociocultural backgrounds and “historical traditions” (van Manen, 1984, p. 38). These backgrounds and traditions, explains van Manen, imbue “meaning to our ways of being with the world” (p. 38). Gall, Gall, and Borg (2003) echo the stance, explaining how phenomenology aims “to understand how individuals construct, and are constructed by, social reality” (p. 481). Given teacher education’s longstanding interest in revising preservice education to look more like medical education, it was fitting to set these two participants’ stories side by side. Despite the fact that entire journal issues have focused solely on various aspects of medical education, a gap remains in articulating how what is learned about the medical education process can be meaningful and productive for teacher education. Granted there were only two participants, I remain confident in my role as researcher that findings can contribute to building a bridge between the medical and teacher education fields. These contributions consist not only of descriptions from educators representing each field, but also include points for consideration detailing how what is learned from one clinical practice context can be used to make necessary, thoughtful revisions in the other. I acknowledge that, ultimately, changes in neither the teacher nor medical education context will occur strictly as a result of the present study.
**Interview Sites**

Since interviews comprised the study’s data collection method, participants’ professional contexts did not have to serve as sites for the study. As the researcher, my intent was to interview participants at locations proving most convenient for them. At the same time, I was aware some locations were not conducive to interviewing due to things like noise level and the potential to compromise participants’ privacy. I thought that finding a quiet space in participants’ workplace might prove ideal.

When it came time to conduct the interviews, the medical educator and I were able to meet at the office he has within the program’s residency office. It is located close to the hospital, but not on the actual hospital campus. We met at the same office for all three of our interviews. The CT and I ended up meeting via Skype. Due to some unanticipated scheduling complications, it made the most sense to meet with one another electronically. Though we were not physically next to one another, Skype gave us the opportunity to see one another as we spoke. As such, we were able to do things like maintain eye contact and see one another’s body language.

The cooperating-teacher-participant is employed by a moderately large school district in the southeastern United States. There are sixteen middle schools and eighteen high schools. The district’s location and size contribute to its diverse student population. The teaching hospital at which the medical-clinical-educator practices is one of the largest hospitals in the state. It is affiliated with the college of medicine housed at the same university as the college of education with which the cooperating-teacher-participant is affiliated. The particular residency program with which the medical-clinical-educator is affiliated has been an official academic entity with the college of medicine since 2003. Consisting of six residents, the residency’s charter class started the three-year program in July of 2006. There were 11 residents in the 2015 class.
Specific Participants

When I began thinking about participant selection for the present study, my personal and professional lives intersected once again. My work as a teacher educator and university supervisor in a large college of education meant I worked with many preservice teachers and cooperating teachers. When I considered the importance of selecting participants with the capacity to thoughtfully articulate their experiences with the phenomenon, several secondary English language arts teachers came to mind. They were practitioners with whom I worked in my role as a university supervisor, collaborating with them in their role as cooperating teacher so that we could support particular student teachers’ completing their culminating clinical practice experience (i.e. the final internship). Though I had no guarantee that those CTs were still involved with the college of education at that capacity, I reached out to the Department of Secondary Education’s Field Experience Coordinator so that s/he could assist me in securing a cooperating teacher participant. Working with the School District, s/he is responsible for placing student teachers that are completing the final internship experience with particular CTs.

While I worked with exemplary CTs from other content areas, my background as a secondary ELA teacher and focus in that area during all of my graduate studies drew me to make the English discipline a criterion for participant selection. Accordingly, the field experience coordinator sent out an e-mail, on my behalf, to cooperating teachers in the secondary ELA area. I did not have access to a list of cooperating teachers so that I could initially and directly reach out to potential participants myself.

As a university supervisor, I worked with cooperating teachers who I believe failed to demonstrate a commitment to their clinical educator role. My belief is rooted in things I observed them do and choices they articulated to me during our conferences. For example, how quickly
they left an intern on his/her own, the lack of feedback they provided an intern, and/or their unwillingness to familiarize a student teacher with curriculum and available resources. I aimed to secure a cooperating teacher who demonstrated commitment to the clinical educator role by doing things like following a gradual release of responsibility (i.e. as called for by particular student teachers), regularly providing novices with feedback through both conferencing and writing, and helping student teachers connect with other faculty and resources both within their immediate clinical practice context and beyond. As this study was carried out, I was neither teaching preservice coursework nor serving as a university supervisor. Further, I was not working with cooperating teachers at the same capacity as before. It serves mentioning that while some may view the potential for me to have known the teacher educator participant through our previous work together as a limitation, such professional familiarity aligns with the methodology. As previously stated, it was important that I knew participants could articulate their experiences with the phenomenon. My researcher reflective journal served as a place for me to explore potential biases.

In the end, the CT participant did not come by way of the e-mail sent out by the Field Experience Coordinator. The cooperating teachers responding to the e-mail did not meet the selection criteria. For example, they were not National Board certified and/or had not been teaching more than a few years. Because I felt being true to the selection criteria was important, I decided I needed to reach out to another person who could help me secure a CT participant. I reached out to a former colleague who has earned the Ph. D. and now works with preservice teachers both in a college of education and in the clinical practice context. She suggested a CT about whom she had heard many positive things from both other professors and preservice teachers. I reached out to the CT via e-mail, sharing the same contextualizing information I
shared with other potential participants. As it turned out, she met all of the study’s selection criteria. She expressed excitement in participating, and we decided to move forward together.

The CT participant, Tori, has 21 years of teaching experience in the secondary English language arts classroom. She has ten years of experience as a cooperating teacher, and there has never been more than a semester that has lapsed between the times she has served as a CT. Additionally, Tori is a National Board Certified Teacher—as an Exceptional Needs Specialist.

Due to my husband’s professional role as a resident physician while this study was being conceptualized, I came to know clinical educators in the teaching-hospital-setting I believed would be well suited to serve participants. It’s important to note that I had never observed them in formal teaching situations. My perceptions were informed by conversations we had and details I learned through my husband (e.g. how a teaching session was structured, documents that were prepared in preparation for a mentoring meeting, etc.). For the purpose of this study, I conceptualized a well-suited participant as a clinical educator who demonstrated attention to professional formation (Cooke, Irby, & O’Brien, 2010; Wear & Castellani, 2000). As previously stated, this means that the clinical educator is intentional in his/her ongoing efforts to achieve “excellence across the domains of practice” (p. 38) so that conditions of the populations they serve are improved. Further, it is “an ongoing, self-reflective process involving habits of thought, feeling, and acting” (Wear & Castellani, p. 603), which cuts through the professional lifespan. As a result of attending various residency functions and professional conferences with my husband, I met and exchanged dialogue with attending physicians who demonstrated a strong commitment to graduate medical education and the professional formation process. I believe they exhibited their commitment to the clinical-educator-dimension of their professional role through such things as undertaking systematic inquiries with resident doctors, sharing resources
to help novices with their developing clinical practice and their job search after residency, and meeting with residents during off-shift times in order to share feedback about clinical skills and assist with goal setting. These physicians were also involved in service to the profession by providing free, informative lectures to the local community, advocating for the profession and specialty at the State and National levels, and helping novice practitioners and patients at the international level. Via e-mail, I reached out to potential participant(s) I believed met much, if not all, of the aforementioned selection criteria. Participants’ e-mail addresses were available on the program’s website. Beyond meeting the criteria listed for participant selection, potential participants held other leadership roles within the residency program. These included things like being responsible for residents’ research activities, the program’s professional journal club, specific interest areas within the specialty (e.g. providing additional training in ultrasound), and the organization of topics for weekly grand rounds. At the time this study was being carried out, my husband had already graduated and was no longer affiliated with this teaching hospital and its clinical educators in any formal capacity. I understood that, while engaged in the series of in-depth interviews, I could have found that my perceptions about the person who ultimately served as the medical educator participant may not have been completely accurate. As with the teacher educator participant, I used my researcher reflective journal as a place to explore such topics about the medical educator.

The attending physician who served as the study’s medical educator participant, and is referred to as Tom throughout the present study, met selection criteria as follows: he has independently practiced in the academic hospital setting for four years; he is Board certified in the specialty he practices (i.e. Emergency Medicine); and, he is a core faculty member.
**Additional Recruitment Procedures**

As previously noted, e-mail communication was used in order to invite potential participants to take part in the study. I reached out to potential medical, clinical educators I believed met selection criteria and would be amenable to participating in the study. Given the criterion sampling strategy (Patton, 1990) and in-depth phenomenological interviewing method (Seidman, 2013), it was appropriate for me to have some familiarity with potential participants prior to the study. The e-mail provided contextualizing information, including brief points from the literature to support the study. I also detailed the time investment involved. Regarding the cooperating-teacher-participant, as stated above, the field experience coordinator e-mailed potential participants on my behalf. The e-mail provided the same information as the e-mail sent to medical, clinical educators. Given the criterion sampling method used for the present study, it was acceptable for me to select the first respondent who met the selection criteria.

Of course, there was a chance that one or both participants could have decided to exit the study. For that reason, I had alternate participants in mind. There were other attending physicians, a part of the same residency program, who also met the selection criteria. Those clinical educators were also actively involved in research with resident physicians, leadership roles with the residency program and beyond, and the teaching of medical students from the local medical school. As far as alternate cooperating teacher participants, should one have been needed, s/he would have been selected based on order of response to the e-mail invitation—provided s/he met selection criteria.

**Protecting Participants**

Though I may have entered the study with certain notions about how participants would respond to questions, those assumptions were rooted in each my lived experiences and readings
of the relevant scholarship. Demonstrating ethical behavior as a researcher meant that I could not lead participants toward certain answers because they resonated with me, were reminiscent of my experiences, and/or aligned with my beliefs. Wolff’s point is pertinent: “Phenomenology asks us not to take our received notions for granted but…to call into question our whole culture, our manner of seeing the world and being in the world in the way we have learned it growing up” (as qtd. in Crotty, 2010, p. 80). I understood that I could not approach the present study attempting to prove particular things as true or false, right or wrong. Seidman (2013) explains it this way, “Researchers seeking their participants’ perspective on their experience and the meaning they make of it should treat interviewing as an exploration, not an attempt to prove something they have in mind” (p. 141).

No interviews took place until the study proposal was submitted to and approved by the university’s Institutional Review Board. As was detailed on the IRB application, participants were able to excuse themselves from the study at any time. Given the chance that one or both participants could have decided to leave the study, plans for including alternate participants were included. Study participants are not identified by name on any documents, and thoughtfully selected pseudonyms were given to each one.

**Procedures & Data Collection**

Following Seidman’s (2013) approach to in-depth phenomenological interviewing, I conducted three, ninety-minute interviews with each participant. Each interview had a particular focus. Anfara, Brown, and Mangione (2002) elaborate on the importance of considering “that research questions provide the scaffolding for the investigation and the cornerstone for the analysis of the data, [so] researchers should form interview questions on the basis of what truly needs to be known” (p. 31). Addressing in-depth interviewing specifically, the three explain it as
a process involving the connection of “etic issues…with emic issues” (p. 31). As exploratory interview questions were crafted, I circled back to the research question as a way to confirm interview questions flowed from it. During the first interview, participants were prompted to share details about their life history and particular professional context. Seidman asserts, “Without context there is little possibility of exploring the meaning of an experience” (p. 20). While I am not asserting that participants’ context (i.e. where they are engaged in clinical education) is the single and/or most significant driving force behind how they make sense of their role and/or their pedagogical choices, I do believe it influences and has the potential to both support and constrain their clinical education practice. Our second interview called for participants to detail their present lived experiences as they related to the study. While participants could use stories as a means for sharing the relevant details of their experience, the point was not for them to spend time providing their opinions on the details of the experiences. It was my responsibility to redirect participants’ focus to the “concrete details” of the experience because, without them, “the attitudes and opinions can seem groundless” (Seidman, p. 91). Finally, our third interview served as a space during which participants “reflect[ed] on the meaning of their experience” (Seidman, p. 22). This exchange allowed meaning about participants’ present lived experiences to flow from the groundwork created during the prior interviews. In this way, participants could come to understand how the context and the reflected on, lived experiences within that context might inform today’s lived experiences.

In addition to suggesting that researchers follow the three, ninety-minute interview structure, Seidman (2013) recommends following a timeframe of anywhere from three days to one week between each of the three interviews. This intentional spacing of time gives participants a chance to reflect on each interview without being so extensive that participants
become disconnected from the topic and the details shared during the preceding interview(s). Participants and I were able to stay close to these suggestions. Pertinent to the present study, van Manen (1984) also shares several procedures he believes interact with one another throughout the course of a phenomenological study. One of those procedures calls for the researcher to study experience as it is lived, not as it is conceptualized. This is pertinent to the present study because the ways clinical educators conceptualize their role in helping novices make meaning from clinical practice experiences may differ from how those educational activities are actually enacted—are lived. Interview protocols can be found in Appendix B of the study.

**Data Analysis**

While some form of data analysis took place while the interviews were carried out (e.g. reading through a transcript in order to craft questions for the subsequent interview), I followed Seidman’s (2013) advice to leave in-depth analysis until all interviews were complete. Anfara, Brown, and Mangione (2002) explain the purpose of data analysis as follows: “to bring meaning, structure, and order to data” (p. 31). In their words, interpreting the data “requires acute awareness of [it], concentration, and openness to subtle undercurrents of social life” (p. 31). Heeding their suggestion, I strove for “analytic openness” (p. 28). Important to understand is that qualitative researchers acknowledge there is no single, correct way to move through the data analysis process (Anfara, Brown, & Mangione; Creswell, 2007). Though I had interviews transcribed by a reputable transcription service, I did not circumvent important parts of the transcription process. For example, heeding Seidman’s advice, I did not send select clips of the interviews for transcription and analysis. In his words, leaving some portions out of the transcription process demonstrates “premature judgments about what is important and what is
not” (p. 118). Also, considering the potential importance of certain nonverbals (e.g. laughter; sigh; ringing telephone), I asked the transcription service to note them.

As a first step in data analysis, I read the transcripts and used highlights to indicate interesting passages. Doing so indicated I had “begun to analyze, interpret, and make meaning” of the transcripts (Seidman, 2013, p. 120). One of the ways I trusted myself as the researcher, and my choices to mark certain excerpts of the transcripts as interesting, was through my study of the literature related to the present study. Seidman explains that, in his experience, some excerpts “stand out because [he has] read about the issue from a perspective independent of [his] interviewing” (p. 129). I used Seidman’s suggested notation system to organize an excerpt’s place in the original transcripts: participant’s initials, “a Roman numeral for the number of the interview…and Arabic numbers for the page number of the transcripts on which the passage occurs” (p. 128).

I took the highlighted excerpts from the transcripts and arranged them into categories. Anfara, Brown, and Mangione (2002) explain that researchers must be open about the process they followed for creating categories. I discussed the process with my peer reviewer. Seidman notes that there cannot be a prescribed set of categories the researcher imposes on the interview data. The researcher must exercise judgment and his/her understanding of the relevant research as s/he creates categories for the transcripts, and these should reflect how participants articulated their lived experiences (Anfara, Brown, & Mangione). Kvale and Brinkman (2009) identify this type of coding as “data driven” (p. 202). It’s important that, throughout the study, I was able to connect things back to the research question and the literature base related to it; this included interview transcripts. Continuing through data analysis, I looked to see if there were “connecting threads and patterns among the excerpts within…categories and…connections between the

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various categories that might be called themes” (Seidman, 2013, p. 127). Making a concentrated effort to keep interview data organized, I created computer files for documents (e.g. interview transcripts) as they evolved through the data analysis process.

**Writing as a Data Analysis Tool**

I was drawn to Seidman’s (2013) preferred mediums for presenting interview data. He has found creating profiles or vignettes of individual participants’ lived experiences as an effective means of “opening one’s interview material to analysis and interpretation” (p. 122). Meaning, crafting the profiles is an extension of the data analysis process. Profiles are best when they prove full enough to have a clear beginning, middle, and end. Additionally, and similar to the necessary elements of a story, they should include conflict and resolution. Given that they reveal participants in their context, elucidate their intentions, and help demonstrate how interviews were components of an intentional process carried out over a particular period of time, profiles are well suited for presenting in-depth interview data. Additionally, they can be particularly influential when they use participants’ voices. Since the aim of in-depth, phenomenological interviewing is to understand participants’ lived experiences “through their stories,” profiles using participants’ original language help “reflect the person’s consciousness” (Seidman, p. 122).

While two of the findings chapters (i.e. chapters four and five) of the present study still make use of profiles, they were crafted in my own words. When it came time to compose the profiles, I felt the data did not lend itself to only using participants’ original language. Seidman (2013) does acknowledge that not all interview data will. The data were too broad in scope to compose a succinct yet still powerful profile for each participant. That being said, some relevant interview transcript excerpts are included within each profile. I believe the extensive interview
data being so broad in scope aligns with a major finding of the study, which will be discussed in the chapters that follow. That is, the clinical educator role is indeed complex and multifaceted—emanating from the whole of who participants are as individuals.

Continuing, and holding resonance with the present study, Seidman (2013) believes profiles have the potential to “link the individual’s experience to the social and organizational context within which he or she operates” (p. 123). It was essential that profiles focused on participants’ lived experiences and the meaning they made of those experiences. Though I was engaged in my own meaning making, as I analyzed interview transcripts and crafted profiles, the present phenomenological study was concerned with participants’ meaning making (i.e. as it relates to their clinical educator role). Seidman writes that interviewers spend ample time with participants “to find out what their experience is and the meaning they make of it, and then to make connections among the experiences of people who share the same structure” (p. 130).

Composing the profiles, I stayed as close as possible to the steps Seidman (2013) lays out. In an effort to be as transparent as possible with all segments of the study’s methodology, the various steps in creating profiles follow. Marking up the text, similar to what one might do while reading a literary work, is an important part of the process. When first moving through reading, marking, and labeling the text, Seidman explains the importance of “keep[ing] labels tentative” (p. 128). He explains that if researchers continue reading and marking transcripts with an open mind, they might see how passages previously appearing disconnected aren’t, how ones presumed meaningful end up left out, and how some “remain in flux almost until the end of the study” (p. 128). I believe his position aligns with Rosenblatt’s (1995) transactional theory; with each reading of a particular transcript, at a particular point in time, the meanings I make can be further crystallized. Just as the reader of a novel, a classroom, or a patient stands to see things
anew by re-reading, I read through interview transcripts a number of times. Seidman, in fact, cites Rosenblatt’s work when he writes, “All responses to a text are interactions between the reader and the text” (p. 120). As I reread the marked up transcript in its entirety, I listened to both my “intuition and intellect” (Seidman, p. 129) so that the result was an accurate synthesis of what participants shared and my response to it. Crotty (2010) expounds on the point this way: “In describing what comes into view within immediate experience…, we necessarily draw on language, on culture. For that reason, we end, not with a presuppositionless description of phenomena, but with a reinterpretation” (p. 82). I selected all passages marked as important and combined them into a single transcript. This new transcript was shorter than the original three-interview transcript. Following, I “read the new version…with a more demanding eye….ask[ing] [my]self which passages [were] the most compelling [and] underline[d] them.” (Seidman, p. 123). At that point, working from the marked up files, I was set to compose the narratives.

Writing was also used during data analysis to help me work through excerpts I identified as important but remained unsure about how to categorize. Seidman (2013), following suggestions by Charmaz and Glaser and Strauss, advises that researchers compose memorandums. Through composing memos, and articulating why an excerpt was selected and the meaning it holds, “the properties and import of the category may become clear” (p. 131). According to Seidman, the final phase of interpreting the interview data called for me to reflect on the entirety of the research experience. Doing so mirrored what I asked participants to do throughout our series of interviews. Seidman proposes researchers use the following to guide their reflection: how did one arrive at studying the particular phenomenon? What was the “research experience” like? And, what has the work come to mean for the researcher? (p. 131). My responses to these guiding, reflective questions are included in Appendix H.
Poetry

Chapter four and five of the present study make use of poetry. Additional poems are also included in Appendix G. Poetry was included as an artistic way to succinctly present the study’s findings. Faulkner (2009) advances poetry as an appropriate means of representing research findings when the researcher deems “other modes of representation” as unfit (p. 17). Using poetry to present findings, according to Faulkner, can help researchers “write with more engagement and connection” (p. 17). According to Faulkner, “Poetry can be used as a tool and method for presentation of research data…and as a source for data analysis” (p. 20).

Each participant profile is accompanied by an “I Am” poem. Given their placement before each Tom and Tori’s profile, the poems act as a sort of conceptual organizer for the reader before entering each profile. The poems help present the essence of the ways participants’ made sense of their clinical educator role. The “I Am” poem is one I became familiar with during my fellowship with the area’s chapter of the National Writing Project. Working with the extensive interview transcripts, and subsequent profiles, the poem seemed an appropriate way to succinctly display some of the most salient findings. In order to provide support for the content of each “I Am” poem, a table is included in Appendix I. Each table includes a line/verse from an individual participant’s “I Am” poem. In the next column, I articulate how the line speaks to the ways the participant made sense of his/her clinical educator role. Finally, there is an interview transcript excerpt serving as evidence for the line/verse I composed. The interview transcript excerpts contained in each table are used within the profiles.
Figure 3.1: Iterations of Data Analysis

Trustworthiness & Validity

In-depth phenomenological interviewing’s structure includes features supporting validity: a particular context frames the relevant details participants share; the intentional spacing of time between each of the three interviews helps account for events (e.g. illness) that might influence a participants’ responses; and, Seidman (2013) believes that if the interviewer and participant(s) emerge from each interview with a genuine understanding of what was shared the process “has gone a long way toward validity” (p. 27). Following recommendations set forth by Anfara, Brown, and Mangione (2002), I provide readers with interview protocols. Doing so aids readers in making their own “validity judgments” about how the study was executed (p. 29).

I align myself with Seidman’s (2013) stance on member checking. Anfara, Brown, and Mangione (2002) identify member checking as helpful toward strengthening a study’s credibility. I discussed with participants that I understood how some of the things they shared throughout the series of interviews could make them feel particularly vulnerable because they were personal in nature and/or connected to their particular professional practice context and the other professionals who work there. Like Seidman, I only wrote things I am willing to share with participants or say to others about participants (de Laine, 2000, as ctd. in Seidman). Regarding participant checks, Mayan (2009) cautions researchers to consider how, as the study progresses and one moves through data analysis and interpretation, they might “jeopardize” (p. 111) the inquiry. This is because member checking can give participants the authority to reject what the
researcher has interpreted and written. While I did not share drafts of my writing with participants, I did share all transcripts from the interviews the particular participant participated in. Additionally, I used peer review to strengthen the study’s rigor (Anfara, Brown, & Mangione). Mayan explains peer review as “the process of engaging another research colleague in an extended and extensive discussion of one’s process in working with the data” (p. 112). Like Mayan, I believe a “critical and supportive colleague” (p. 112) played an important role in tending to the study’s trustworthiness and rigor through his/her ongoing dialogue with me about the data, my interpretations of it, and the iterative writing process I moved through as I crafted participant profiles and other parts of the findings and discussion chapters. When I engaged in review sessions with this colleague, in order for them to be productive, I was clear that I expected him/her to ask “hard questions about methods, meanings, and interpretations” (Creswell, 2007, p. 208). It would not have been constructive toward strengthening the study’s trustworthiness and validity if the peer reviewer did not offer critical feedback and, rather, felt compelled to commend all of my choices and withhold questions about them. Per Creswell’s suggestion, I kept written documentation of our review sessions. I worked with a peer who had already earned the Ph. D. in the same concentration area. This person has experience with designing and carrying out a qualitative study. Further, s/he has professional work experience in both the secondary English language arts and teacher education contexts. Though s/he has not necessarily read deeply into the medical education literature, s/he has familiarity with the teacher-education-literature-base informing the present study. This serves mentioning because his/her understanding of the literature meant s/he was able to help me ensure that I made accurate connections between findings and said literature.
Tending to internal consistency, I considered whether or not what participants said in one interview related back to what they said in others. Moreover, I studied transcripts to determine if what participants shared connected “to a broader discourse on the issue” (Seidman, 2013, p. 29). Regarding the question of whose meaning was made, either the interviewer’s or participants’, I align myself with Lincoln and Guba (1985) and Seidman. These scholars acknowledge that, in a qualitative inquiry, the interviewer is the research instrument. Rather than viewing this as a limitation of the study, or as something making findings less valid and/or reliable, it can be viewed as a strength. One can consider that a skilled researcher (e.g. interviewer) has the ability to respond to situations in ways that are not possible if the research instrument is, for example, a survey. As such, one might argue that when the researcher-interviewer is the research instrument findings can be richer and more meaningful. The meanings made throughout the course of the study (e.g. during interviews) undoubtedly stem, to some extent, from the interactions shared between the interviewer and participants.

**Role & Perspective of Researcher**

My role as the researcher called for me to thoughtfully apply my skills as a novice qualitative researcher and demonstrate my capacity to thoughtfully interact with people whose professional values and beliefs might have differed from mine. Demonstrating skill as an interviewer meant that I had to notice when to strike a balance between things (e.g. jumping in too quickly to cut silence) and how to best strike that balance. van Manen (1984) believes, in the context of a phenomenological interview, such skills are actually demonstrative of an artistic sensitivity. As a phenomenologist-interviewer, I believe I showed myself to be aware of the many subtleties of language that were bound to be a part of the series of interviews. I was also intentional in co-creating and nurturing the delicate balance between personable and professional.
I position myself with Seidman’s (2013) stance, which supports researchers’ efforts to share enough relevant details of their lived experience to show them as the attentive, “alive and responsive” people they are without compromising the “autonomy of the participant’s words” or causing the attention to shift from participants’ stories to the interviewer’s (p. 98). I believe my experiences as a classroom teacher and teacher educator helped me find the best balance between a friendly relationship and a relationship in which interviewing was used as a means for understanding a particular issue. I was capable of maintaining the integrity of the relationship I established with participants without being too distant.

Lincoln (2005) underscores the importance of researchers reflecting on all facets of a study and the values they, themselves, may ascribe to those facets. Pertinent to this study, Paul notes that a constructivist perspective (a) acknowledges the value-laden nature of inquiry and (b) encourages researchers to confront the values informing their thinking. Throughout the study, I maintained a researcher-reflective journal so that, through the intentional act of writing, I could work to make my own meaning of my experiences as the researcher and hold myself accountable for how my personal and professional backgrounds may have influenced those experiences. Bochner’s (2005) point is fitting. He makes clear that the describer-researcher can never fully divorce him/herself from the objects and/or subjects of description. Though the present study employed an in-depth phenomenological interviewing methodology and was concerned with the essence of participants’ experiences not, for example, how my professional experiences resonated with theirs, my personal and professional backgrounds, along with the interviewing relationship we created, could not be fully untangled from the study’s findings. Articulating some of the philosophical tenets underlying reflexivity, Mayan (2009) explains reflexivity as “the process of being highly attentive to how and why you make decisions and interpretations
along the research way” (p. 137). Anfara, Brown, and Mangione (2002) view reflexivity as a tool in helping researchers achieve confirmability. This reflexive way of being shares characteristics with the phenomenological beliefs (Seidman, 2013; van Manen, 1984) informing the present study. Reflexivity, like phenomenology, is an intentional habit of mind integral to making meaning of lived experiences and helpful in appropriately informing actions.

van Manen (1984) takes the position that an entry point to phenomenological research is the researcher discerning some thing s/he’s “deeply interest[ed]” in and, then, ensuring that it is “a true phenomenon…some experience that human beings live through” (p. 40)—a position shared by Gall, Gall, and Borg (2003). The latter extend the their outlook by articulating the essentiality of the researcher not only seeking to understand something s/he’s intellectually invested in, but emotionally as well. For over a decade, partly due to my husband’s professional role of physician, I have had an interest in the medical education process because it has played a significant role in my personal life. Stepping into the role of classroom teacher, I grew increasingly interested in understanding my husband’s professional experiences through an educator’s lens. When I began doctoral coursework, I had opportunities to read medical education scholarship and interview a medical educator-practitioner. These undertakings were done alongside my work in the teacher education context. Consequently, I came to know that my interests in particular facets of medical education were indeed phenomena experienced by human beings in the medical education context. Entering this study, I sharpened my interest in a particular part of the clinical practice experiences given to each novice teacher and medical practitioners so that, through the use of in-depth phenomenological interviewing (Seidman, 2013), I could make a small contribution to the scholarship in the teacher education and medical education fields.
I acknowledge that some researchers may view my lived experience with teacher and medical education as limitations to the study because of their potential to bias me in my researcher role. As a phenomenologist, aligning myself with van Manen (1984), I view my lived experiences with both contexts as strengths. To some degree, those experiences helped me acquire “a sense of practical wisdom” about those I “have pedagogical interest” in (p. 50). Like other qualitative researchers (Lincoln, 2005; Mayan, 2009), I believe all researchers bring biases into a study—this is part of being a cognizing human being. Aligned with an interpretivist stance (Paul, 2005), I bring sets of assumptions and biases into a study because I am a person who thinks about her lived experiences to make meaning of them (ontology) and I use language to interact with the world and “attach significance” (p. 47) to my lived experiences (epistemology). Confronted and kept in check throughout the course of a study, biases are not necessarily detrimental. Mayan (2009) characterizes bias in qualitative research sampling as a strength, for it can help researchers more deeply understand particular phenomena. van Manen’s explanation of the “pre-understandings” a researcher brings to a phenomenological study is fitting; he explains how these understandings “predispose us to interpret the nature of the phenomenon before we have even come to grips with the significance of the phenomenological question” (p. 46). Seidman (2013), too, notes how researchers enter the study with biases and assumptions as a result of their formal study of scholarship surrounding the particular phenomenon. However, van Manen makes clear that these “presuppositions” will reveal themselves as “shallow” (p. 46) when we repeatedly look at them within the context of the formal study. Put against data collected and analyzed as part of a phenomenological inquiry, our “pre-understandings” (p. 46) may show themselves to be void of the meaning needed to make the phenomenon a “knowable” (p. 49) part of the present.
**Limitations**

While I hope the present study contributes to both fields’ ongoing efforts to formally study, better understand, and improve clinical practice experiences, it is important to remember that the descriptions shared represent a single interpretation (i.e. my interpretation) of participants’ lived experiences. Though I had checks and balances (e.g. peer review) in place to assist in ensuring that my interpretation was on point, other potential interpretations exist and may serve to bolster my interpretation’s fullness (Seidman, 2013; van Manen, 1984).

Next, I feel comfortable with Seidman’s (2013) stance that we must “allow considerable tolerance for uncertainty…in the way we report what we have learned from our research” (p. 132; Bronowski, 1973, as ctd. in Seidman). Though the present study might have helped participants to both learn from their experiences as clinical educators and understand that role in new ways, ways potentially having a positive influence on future professional practice, it might have also left them with questions about particular facets of their professional practice that they did not have at the study’s onset. To be sure, this is not necessarily a negative thing. But, I could not predict that such questions would surface, how participants would work through them, and whether or not they would influence participants’ role of clinical educator. To some extent, the aforementioned aligns with Mayan’s (2009) assertion that the “crux” of phenomenology “is that it is the study of a prereflective lived experience, or what we do automatically, without thinking about it” (p. 49; Gall, Gall, & Borg, 2003). Analogously, the study might leave some readers with additional, complex questions about certain features of clinical practice experiences in the professional education process. The purpose of the present study was not to provide final, definite answers to its exploratory question.
Chapter Summary

To underscore, the present study’s purpose was to describe how professional educators (i.e., cooperating teachers and attending physicians) made sense of their role in helping novice practitioners make meaning from authentic clinical practice. The inquiry sought to offer insight to the following exploratory question:

In what ways do professional educators (cooperating teachers and attending doctors) make sense of their role in helping novice practitioners make meaning from authentic clinical practice?

The preceding chapter elucidated how in-depth phenomenological interviewing was used to get at findings to the research question. I detailed my belief that Seidman’s (2013) approach to interviewing was an appropriate research method because of its focus on participants’ stories and that each interview had a particular purpose, which helped focus my questions and participants’ attention. Throughout the chapter, I provided support for the decisions I made in my researcher role. For example, why a sample size of two participants was appropriate and why there was slight variation in participants’ selection criteria. Given that this study was guided by a particular phenomenological method, it was interested in participants’ lived experiences with the phenomenon and not with mine. Still, since I could not fully divorce myself from the experiences that brought me to study the phenomenon, I accounted for how I was mindful of researcher bias. Maintaining a researcher reflective journal, in lieu of the bracketing commonly associated with phenomenology, is something I did through all phases of the study. There was also member checking and peer review. A visual was included to help underscore and simplify aspects of the methodology.
CHAPTER FOUR: PROFILING TOM, THE ATTENDING PHYSICIAN

The purpose of this phenomenological study was to describe how professional educators (i.e. cooperating teachers and attending physicians) make sense of their role in helping novice practitioners make meaning from authentic clinical practice. Setting their stories side-by-side helps show where these two clinical educators similarly made sense of their clinical educator role and where they diverged. In order to understand how clinical educators make sense of their role in helping novice practitioners make meaning from authentic clinical practice, I asked, “In what ways do professional educators (cooperating teachers and attending doctors) make sense of their role in helping novice practitioners make meaning from authentic clinical practice?”

In chapter four, I introduce Tom, the attending physician; in chapter five, I introduce Tori, the cooperating teacher. I begin each of these chapters with a poem that provides the reader with a succinct representation of some of the most salient findings. Details about my choice to include poetry were included within chapter three. I then provide a profile for each participant. These profiles begin with participants’ relevant background experiences and continue to the present day. I composed the profiles with attention to what emerged as the most salient findings during data analysis.

After presenting each participant as a clinical educator, in chapter six, I look across the two participants and offer an across-participant-analysis. There, I articulate where participants’ stories are either similar or dissimilar.

**The attending physician: I am Tom**

I am a multifaceted thinker.  
I wonder if I can instill curiosity.
I hear their questions—things I hadn’t thought about since my neophyte days.
I see them growing in their capacity to study problems of practice.
I want them to own the tools.
I am a multifaceted thinker.

I pretend to be more confident.
I feel hesitant to show all parts of me.
I touch lives—patients, practitioners, and novice physicians learning to be.
I worry we aren’t doing enough.
I lament lost opportunities.
I am a multifaceted thinker.

I understand we don’t have it all figured out.
I say keep questioning, developing, and doing.
I dream of a capable, confident, and unified tribe.
I try to share all of who I am.
I hope to broaden the scope of whom I’m able to reach.
I am a multifaceted thinker.

**Professionally Oriented Lived Experiences**

For Tom, work experiences began when he was 15-years-old, but his efforts to pursue medicine did not begin until eleven years later. From the time he finished high school, Tom was intent on entering academics—it’s the reason he pursued a college education. He was focused on entering the social sciences; specifically, the field of anthropology. Tom’s ways of making meaning of the world, inclusive of things like his role of clinical educator and its concomitant tasks, are influenced by his thinking like an anthropologist. Through his role as a student/research assistant, Tom learned a great deal about academia. Eventually, he entered graduate school and funded his education by working as a graduate assistant.

Speaking with Tom makes clear that these early experiences in higher education, in the role of teacher, have come to bear on his present role of clinical educator. For example, during his time as a graduate assistant Tom was motivated to seek out professional development opportunities that he believed would help him develop his pedagogical skills. He recognized where he was lacking in his role of teacher and was intrinsically motivated to do something
about it. Such reflective practice and professional development pursuits are a part of his present day practice. Having always wanted to be a teacher, Tom thinks about his teacher role when enacting his medical practitioner role, performing the functions associated with that role, and participating in activities related to that role. His experiences in academics helped solidify the role of teacher as one woven through his other roles. Previously, he was not strictly an anthropologist or strictly a teacher. Today, he is not strictly a doctor or strictly a teacher. Tom’s reflections and descriptions manifested how he sees that a number of roles work in tandem.

Tom did not leave academics because he grew disillusioned with his role in that realm. The role of teacher remains a substantial part of who he is and, when pursuing medicine, he was focused on entering medicine as a teacher. Going back, after making it to the second round of the Fulbright Scholars Program, Bolivia, where he planned to conduct his fieldwork, was overthrown. Hence, due to the revolution and Fulbright rules preventing work in such conditions, he found himself at a crossroads. He needed to decide what he was going to do, professionally, given the unanticipated outcome. It was at these crossroads where emergency medicine and academics met. Tom’s mentor, Ben, served as an advisor (i.e. member of a thesis committee) for a number of emergency medicine fellows completing an international medicine fellowship. As a part of their research and affiliation with Ben, the fellows used the research lab where Tom worked with Ben as a site for their physiological experiments. Tom got a glimpse of how medicine and academics could pair. He realized that a life in academics would be difficult—even finding a job would prove arduous. At 26, he felt he was young enough to shift career plans and pursue medicine. He felt it was a logical decision because he could bring what he liked from academics (e.g. research; teaching) into medicine (i.e. working as an emergency medicine practitioner to help patients).
During medical school and residency, Tom became aware of the lack of standardized pedagogy in medical education and the weak teaching that permeated the medical education environment. Given his identification with the role of teacher, he was particularly aware of these problems and moved through residency with the mindset to work to improve them. As mentioned, Tom went directly from completing residency into academic medicine. Since his goal had always been to teach, from the onset, performed functions of the teacher role typically reserved for core faculty. He arranged his schedule in ways enabling him to act as a core faculty member and was intent on having formal interactions with residents. Tom wanted to do more than interact with residents simply as a byproduct of the context where he practiced and took it upon himself to do things like attend Grand Rounds and lead the program’s journal club.

**Professional Development**

After gaining even more experience in his roles of clinical educator and emergency medicine physician, Tom decided to spend time practicing in the community setting as well. He felt moved to do this because practicing in emergency rooms around the community, ones not located in a teaching hospital, would better equip him to prepare novice practitioners for the kinds of contexts many would enter. By gaining familiarity with other “communities of practice” (Lave and Wenger, 1991) and their problems of practice, Tom can help novices anticipate the kinds of things they might see once they complete formal clinical education. He is well aware of the limited time formal clinical education offers: “[Y]ou have 36 months, 18 of those in the ED…. Each one of those is one pluck off the learning tree…. That opportunity’s gone to have an experienced provider, sitting right in front of you, with knowledge” (Interview 1). The professional knowledge he builds from his experiences in the community ER setting helps create additional ways to unpack novices’ authentic clinical practice experiences. Worth remembering
is that Tom chooses to engage in this particular kind of professional development of his own accord. He recognizes that it is beneficial for his clinical education practice and, in turn, the novice professionals he works with.

Continuing, Tom sees it as his responsibility to create professional development opportunities for himself because graduate medical education is lacking in its efforts to teach the teachers. For example, as he attempted to enact his role of mentor—an extension of his clinical educator role—he realized there was no preparation for mentoring. No specific tools were shared with him to help him effectively mentor novice practitioners. Given his desire to teach and his sense of intrinsic motivation, these program-wide-weaknesses weren’t wholly detrimental to him because he viewed them as opportunities to develop his own mentorship program. Yet, he recognizes the weakness in that approach, as it means that all mentors interpret and enact the mentorship program differently. He expressed, “GME’s probably behind…on how they think about teaching teachers, and always has been…. GME probably should offer to people who want to be teachers…those exact tool sets you need” (Interview 2). Tom has experienced the effects of a lack of professional development and standardization since his days as a graduate assistant and through his own medical education. Accordingly, he attempts to bring the program’s core faculty together, for formal meetings about teaching and learning issues, as much as possible. Given his many responsibilities and the limit of time, there is only so much he can accomplish on his own.

Mentorship is particularly important for Tom and something he invests time in further developing because, since his time as a graduate assistant working with Ben, mentorship has proved instrumental in shaping his professional role and practice. Tom articulated: “I think any residents should be able to come to any one of the 10 core faculty members…and get a great mentorship experience…. [W]e have to have some tools there…. Teaching the teacher kind of
thing” (Interview 3). Though no longer a novice practitioner or novice educator, Tom values and seeks out mentorship from professionals in varying capacities. He takes the stance that not doing so, not having those relationships with other professionals, would prove detrimental to his professional role and practice. He feels strongly that without continuous mentorship and professional development one is at an increased risk for burning out. Recognizing the educational promise in learning from others who are at different stages of their professional lifespan, Tom has created opportunities within his mentorship program for novices to learn from other novice professionals who are at a different stage of the process (e.g. a second and third year resident working together on a particular problem of practice).

Tom’s mission to be in an ongoing cycle of professional development has not slowed as he has gained more experience and grown in his professional roles. In fact, he felt it important the residency program formalized its approach to faculty development. There has been some improvement, as there is now a monthly meeting where core faculty can sit and discuss issues specific to teaching and learning. Tom shared, “We now have a monthly just-core-faculty-member meeting to talk about education-related things…. [T]hings that you want to talk about as a core educator who’s trying to get better at this and whose mission is to do this...” (Interview 3). Still, Tom believes there needs to be an increased number of formal occasions for faculty, hospital wide, to participate in professional development opportunities like faculty retreats. Tom recognizes systemic issues and makes an effort to improve things for his particular residency program.

Despite how tied he feels to the role of teacher, Tom intends on broadening the scope of his work. Given his goal orientation, he accepts and engages in professional responsibilities aligning with his goal of creating a hospital wide position that will allow him to participate in the
practices of emergency medicine and education, as well research. He stated, “I’m looking at that role growing to an entire-hospital-research-director type of role…” (Interview 2). Tom is energized by having a combination of administrative and education related responsibilities. Being someone committed to building the professional field, evident by his commitment to research, he is drawn toward leadership roles. For him, leadership roles present opportunities to help the population(s) he serves in different ways than those made possible strictly through practicing medicine. He is not concerned with climbing up rungs of the professional ladder for the sake of attaining more power and responsibility; rather, through the power and responsibility he can improve conditions for particular people.

**Humble Leadership**

Leadership and humility, like the medical practitioner and clinical educator roles, are woven together. Tom keeps himself honest about the fact that he does not know everything about practicing and teaching emergency medicine. He recognizes, and models for the novice professionals he works with, the need to ask questions of more knowing others across the professional lifespan. He understands that he can and must learn from both formal professional development and others’ wisdom of practice. Hence, he is intentional in modeling these cognitive and behavioral processes for novices. For instance, he is sure to let novices see him asking other emergency medicine practitioners questions about particular cases and for help with particular procedures. He sees it as ineffectual to reach a point when one deems it unnecessary to ask questions.

**Not Accepting the Status Quo**

Rather than simply accepting that teaching the teachers is a weak component of medical education, Tom creates opportunities for teaching novices how to teach. Not only do some of the
novices he works with express an interest in teaching, but he is aware that many of them might go on to work at teaching hospitals where they will be expected to teach. Tom has created a teaching track within the residency program. Residents who express an interest in teaching, and he identifies as demonstrating the capacity to teach, can follow the teaching track and partake in opportunities designed to help them develop their pedagogical skills in the clinical environment. Creating these kinds of teaching and learning opportunities is not something that is spelled out in Tom’s contract. Rather, taking these kinds of actions in order to propel novices’ learning forward—from as many directions as possible—is something Tom does because he understands the weightiness of directly teaching particular concepts and skills; further, his unique background, coupled with his unique mix of attributes, make it so that he is intrinsically moved to do so.

Tom’s motivation to further develop teaching and learning does not predominantly emanate from mandates and/or lists of expectations generated by some outside organization (e.g. Accreditation Council for Graduate Medical Education); while he is mindful of such things because it is a part of his professional responsibility to do so, his actions are guided by more complex cognitive processes than simple application. Tom has personal attributes (e.g. intrinsic motivation; reflective habit of mind) that come together and help make him be the kind of clinical educator and practitioner who goes above and beyond the status quo. For example, Tom does not operate on the stance that certain parts of the professional role (e.g. showing empathy) shouldn’t be taught. He is empathetic and sure to model and discuss the importance of empathic practice with his residents. He shared, “[I]f I hear a presentation where a resident sounds cold…. Let’s sit down, think about this for a second…. That’s your wife…. That’s your kid…. In that belly, that’s your baby, now let’s just re-have that conversation” (Interview 2). Rather than accepting empathy as too difficult to teach, he makes concentrated efforts to have novices place
themselves in a patient’s position as a way to help novices understand the importance of showing empathy when relaying medical information in an emotionally charged situation.

**Discussing Professional Practice**

Though Tom acknowledges that a good portion of teaching in the clinical practice context involves teaching novices through particular algorithms, he understands that much of what he does in his work as an attending remains qualitative in nature. If novices aren’t engaged in meaningful discussions about the qualitatively oriented domains of the professional’s work, they run the risk of entering the professional practice context not knowing what to do when a scenario deviates from an algorithm. He explained,

> We have algorithms, but we fall off of them all the time, constantly. I can teach algorithms. That’s one form of teaching. It’s part of our responsibility. That’s what grammar is for.... We’ll make sure you know all these algorithms. What do you do when you fall off the algorithm? How do you approach the patient? That’s what I mean about the curiosity part, the thinking part, the asking questions part, that’s where you get those things. That’s part of my job too. (Interview 1)

Tom engages novices in discussions that help make qualitatively oriented domains of the physician’s role visible to them. He aims to help novices—many who have spent decades thinking and learning about the world in what they perceive as more definite terms—feel comfortable in situations that do not have clear cut answers and may involve more emotionality than they are initially comfortable with.

Tom also shows intentionality in helping novices understand why particular processes are in place. Rather than letting novices dismiss a process and/or policy they must adhere to as senseless, he focuses on teaching them about the larger systems at play and why particular processes and policies have come to be. If novices learn to unearth why particular things are the way they are, specifically in relation to their own professional practice, Tom believes they are better positioned to make studying problems of practice a part of their repertoire. Further, he
understands how nurturing such a big picture way of thinking, coupled with an inquiry orientation, helps foster novices’ capacity to build the professional field throughout the course of their professional lifespan. As he sees it, novices can come to grasp how connecting one’s practice to the broader professional context, and formally studying problems of practice with such consideration, can help contribute to the creation of health care related policy at the local and national levels. He expressed, “They’re supposed to be learn[ing] to run the department by the third-year…. [That] means collaborative approaches to patient care, leadership, starting to think about their lives as attendings in terms of how they would change policy and process” (Interview 3).

Tom believes it is essential for novices to understand that they are a part of something bigger than themselves. Their professional practice is concerned with more than their own professional role and their particular patients. Tom shared the following:

Behind you there, I had a resident here a couple of days ago. I had one of the big cardiologists in here a couple of days ago. My resident was really interested in a question of a special kind of heartbeat called atrial fibrillation and whether we were doing it the right way. I said, ‘Well, let’s get a group of people together and we’ll talk about it, and we’ll see what we think, and we’ll see if we can come up with a study for it.’ (Interview 1)

He believes novices must come to know how the choices they make about their practice and their patients can have a trickle effect on the entire emergency department and into other medical specialties.

Tom is aware that it takes more time than what he and novices have during regularly scheduled clinical shifts to discuss varying aspects of professional practice, so he finds other points in time when he can meet and work with them. As an example, he stays after shifts to help novices make meaning of particular cases. While, like novices, he also completed a twelve-hour shift and might feel cognitively, physically, and emotionally spent, he understands the
importance of making the time to debrief professional practice. He recognizes that if he doesn’t make the time to guide novices’ meaning making they might arrive for their next shift prepared to make the same mistakes. Because Tom believes that his role in novices’ meaning making matters toward their learning and development, he is intentional in helping them come to understand why certain things might have played out the way they did and how similar situations can be approached in the future.

Tom also believes it is important for debriefing to regularly occur in the group setting—the emergency department as a whole. He shared, “It’s useful to pull…residents together. There’s a sense of self, ‘This is us, this is our tribe. This is who we are. This is how we act. This is how we behave. This is how we see the world’” (Interview 1).

Still, Tom believes it is important for novices to talk through things themselves. Due to his professional knowledge, he is able to identify when a novice’s thinking falls off course and how best to intervene. There are times when intervening means directing novices to a particular resource. There are times when intervening means asking additional questions. As Tom sees it, the practice of emergency medicine is interested in solving problems. This stance plays into how he joins novices to solve problems with them instead of for them.

Tom believes it is important for novices to, in addition to working through problems of practice, actually experience failure. He shared, “[T]he ability I have of seeing thousands and thousands of patients is I know when your failure is going to be a danger and I can step in. [U]ntil your failure is a danger, there’s no reason…” (Interview 1). He takes the stance that if he automatically steps in and makes corrections for novices, they are unlikely to learn why something is wrong and will continue making the same mistake. If he lets them fail and then
unpacks those failures with them, the failures can lead to progress in novices’ learning and development.

**Attentive to Novices’ Needs**

Seeing the things novices both question and fail at helps Tom consider what has becoming tacit knowledge to him. Thinking about what has become automatic to his practice is part of working as a clinical educator in a teaching hospital. Just as he helps novices understand the importance of putting themselves in their patients’ place, he puts himself back in novices’ place. He goes back to his time as a novice practitioner who did not yet have such refined (a) cognitive and behavioral processes and (b) practical knowledge and skills. He shared,

> Every July, chest pain is brand new again.... I literally hear that in my mind every time a third year medical student presents to me I think, ‘This is all brand new to this person.’ I can literally put myself right back in 2004. I say, ‘OK, see yourself in 2004, this is all brand new, this whole thing is brand new.’ That is to remind yourself over and over again…. (Interview 2)

Tom believes part of his clinical educator role is working with novices to help them develop the habits, knowledge, and skills needed in order for them to, successfully, practice independently. He does not see leaving novices to figure everything out for themselves as worthwhile. Additionally, he does not see relying strictly on a lecture format for presenting novices with necessary parts of the professional knowledge base as productive. Tom spends time thinking about and working to strike the right balance between things like (a) letting novices struggle through a procedure and stepping in, and (b) presenting information about a particular concept through lecture and having novices read about it independently.

Tom has demonstrated an awareness of learners’ needs since his time as the lead graduate assistant for his anthropology program; then, he felt it important to create some standardized materials for all graduate assistants to use so that learners had a fair chance at each learning from
and succeeding in the course. As a leader within the residency program, he believes it is important for all of the clinical educators to discuss novices’ needs and be on the same page so that residents have productive clinical education experiences regardless of the educator they work with. By engaging in reflective dialogue about particular aspects of novices’ learning experiences with one another, Tom believes he and other colleagues demonstrate a sense of heightened awareness about their clinical educator role. Such heightened awareness is pivotal to ensuring that each curricula and program development occur with learners’ needs in mind.

**Evaluating Novice Practitioners**

Improvement, during authentic clinical practice and beyond, can be spurred by evaluation. Tom understands that his role calls for him to formally evaluate whether or not novices are making sense of and retaining what he and other faculty members have taught them. Though Tom acknowledges that the program likely overuses evaluation, he finds a way to make the data generated by evaluations useful to his clinical educator role. For example, taking the time to review residents’ scores on their monthly tests helps him discern when a particular resident might have an extenuating circumstance (e.g. a difficult personal situation) and need support working through it in ways not compromising his/her professional responsibilities. Tom’s personal attributes (e.g. care for learners’ well-being) combine with what he views as functions of his role (e.g. using data generated in practice). Additionally, while Tom might not entirely agree with evaluating residents after each clinical shift, rather than complain, he considers ways the program might be able to make realistic, thoughtful improvements and how he can make present procedures productive.
Ongoing Self-Reflection

Tom’s ongoing self-reflective process has contributed to his achievements. He asserts that he is naturally reflective and recognizes how his reflective habit helps drive his professional development, as it helps him recognize his weaknesses, remain mindful of them, and seek professional development opportunities accordingly. Tom is forthcoming about his weaknesses so that novices understand that he, like them, has to work at continuously improving aspects of his practice and that doing so is achieved through a commitment to learning across the professional lifespan.

Tom’s commitment to learning across the professional lifespan helps him grow increasingly confident in various parts of his clinical educator role, and he then becomes more willing to share those parts of himself with novices. To illustrate, as he feels more capable showing the connection between politics and the practice of medicine, he is more open to bringing novices to meetings he has with legislators. Tom shared, “Part of [it]…is being confident in all the aspects of who I am as a physician, to model them and show them, and not put them to the side and say, ‘That’s just something I do’” (Interview 3). In this way, Tom is able to each model for and directly discuss with novices what he believes are parts of the whole-doctor-role.

Hallmark of Professional Role

For Tom, bringing novices into understanding with what he believes it means to be a doctor is at the heart of being a clinical educator. He articulated, “It’s teaching them what my version of being a doctor is…. My version of being a doctor is this community leader, academic person who’s also a very good healer of patients” (Interview 2).
Being a doctor and a clinical educator emanate from a broader sense of who he is. Roles Tom plays in life (e.g. father) bleed into his professional, clinical educator role and there is no way to fully segregate those. Actually, he believes novices need to develop an awareness of how the many roles they play are entangled and the resulting mesh can be used to better perform the professional role. To illustrate, Tom’s mindfulness of his father role and teaching his son how to do things he now considers basic, like using a spoon, help him be attentive to what has become tacit knowledge for him in the professional practice context but is not yet in novices’ realm of knowledge.

In order to most effectively educate novices in ways conducive to their becoming and being what Tom believes fully captures the role of physician, he must model the entirety of his life. In light of appropriate professional boundaries, he cannot keep parts of himself closed off to residents. By modeling and discussing all parts of his life (e.g. the ability to achieve what he considers an acceptable work-life-balance), he is better able to guide novices’ experiences in ways useful for paving the type of life they seek. For Tom, becoming a physician meant becoming an educator. Being an attending includes being a teacher, researcher, and leader. It is his responsibility to teach novices how these facets of the professional role are in a sort of network. Tom articulated, “My mission is to show what it is to be a doctor, the whole package…. To recognize that is going to be behavior-based, and also knowledge-based…. It’s not just one piece here or there. It’s teacher, educator, community leader…” (Interview 2). Tom sees teaching in the clinical practice context as characterized by modeling and then unpacking modeled behavior. Accordingly, he must model what he believes a doctor to be and then engage novices in conversations about what they observe him do.
Conclusion

The research question that stimulated the development of this narrative was, “In what ways does Tom make sense of his role in helping novice practitioners make meaning from authentic clinical practice?” Throughout our series of interviews, Tom demonstrated himself to be in tune with the complexity of his clinical educator role. He articulated his belief that the ways he makes sense of his clinical educator role are bound up with other parts of who he is. It became evident that his long held interest in becoming a teacher did not dissipate because he transitioned from anthropology in the higher education environment to medicine. His interest in teaching steered him toward academic medicine and helps drive his professional work forward. That is, he is motivated to attain excellence in all aspects of who he is because he understands his clinical educator role to mean that he needs to expose all of those aspects to novices and teach them how to thread those aspects throughout their professional role.

Chapter Summary

This chapter provided a profile of Tom, the attending physician. I began the chapter with an “I Am” poem, which served as a conceptual organizer; it succinctly represented Tom’s experiences that shed light on the ways he understood his role. Details from Tom’s professional background experiences were included, as they have come to bear on his clinical educator role. I shared details about the mentorship he received in the field of anthropology and his subsequent transition to the field of medicine. The reader got to know how Tom values professional development, works to formalize it, and is steadfast in creating opportunities for teaching within the residency program. Also, though he has a leadership role and envisions broadening its scope, he remains humble. His humility, and other personal attributes, helps him when engaging with novices. Further, he is able to place himself back in novices’ position of limited professional
knowledge and experience. Tom’s continuous cycle of self-reflection helps him develop as a professional, as well as make improvements for the residency program. Tom continues gaining confidence in what the role of physician has come to mean for him. It is a role that includes attention to academics, leadership, and healing patients.
CHAPTER FIVE: PROFILING TORI, THE COOPERATING TEACHER

The cooperating teacher: I am [Tori]

I am positive and progressive.
I wonder if I negatively impacted those who came during my early years.
I hear myself saying the wrong thing: “Read it again. Just read it again. Read. It. Again.”
I see that I need to be better for these kids.
I am positive and progressive.

I pretend I am Carol. Asking what needs asking. Leading.
I feel a sense of pride. Teaching is a profession.
I touch my failures—still fresh. Humility envelops me.
I worry I will be too harsh. They won’t learn. Striking the right mix.
I lament lost opportunities.
I am positive and progressive.

I understand their struggle.
I say I’ve been there too.
I dream of the day they are willing to teach me.
I try to sustain collegiality. Back and forth.
I hope I support them in the right ways.
I am positive and progressive.

Professionally Oriented Lived Experiences

Tori shared details about her professional background and education. She revealed how many of the choices she made early on were partly influenced by her husband’s professional responsibilities. The two met in high school, he a senior and Tori a junior, and he joined the Marine Corps. His parents, both teachers, encouraged Tori to pursue a teaching job because it would give her the flexibility to find a job anywhere around the world. Tori was not interested in teaching and was, in fact, interested in pursuing a career in nursing. Due to their move to one of the Marine’s bases, and the realization that her in-laws made some valid points about job security, Tori enrolled in education coursework.
During her own clinical practice experiences, she found herself working as a mental health technician at the children’s health crisis center. On weekends, she helped provide schooling to children at the center. Through this clinical practice experience, Tori had a touch point with the field she was initially interested in and learned how some aspects of healthcare (e.g. working with special needs students) could be paired with education. Her clinical practice experiences helped solidify the role of teacher as one she felt comfortable in. Due to the nature of her husband’s work, they moved a number of times during Tori’s education. Still, she finished her undergraduate work and moved immediately into graduate studies, earning her Master’s degree in education.

Working as a mental health technician, Tori learned and experienced things that inform her present role of clinical educator. For example, she learned about the importance of establishing and nurturing relationships with colleagues as well as how to respectfully communicate with various kinds of professionals. More specifically, she learned the importance of being attentive and responsive to various personality types. Tori remembers how certain medical professionals came off as dry (e.g. predominantly communicating in clinical, medical language), and she is now intent on being approachable. She understands that if she ignores a particular learner’s personality traits, that learner may choose to close him/herself off to her and, consequently, opportunities for learning might be lost. Tori has come to realize that she doesn’t need to fully agree with another professional or novice practitioner in order to have a productive, collegial relationship with that person.

Tori feels fortunate to have worked alongside some exceptional teachers during her clinical practice experiences. Her CT, Carol, was a respected teacher both within the particular school where she taught and in the broader community. Carol was active in some local teacher
organizations (e.g. the area’s chapter of the National Writing Project), and Tori observed how her leadership outside of the classroom influenced her work within it. Her CT was also a National Board Certified teacher and Tori, though admittedly intimidated by her CT’s many accomplishments and perceived power, was introduced to how strong professional networks and the habits of mind and action strengthened through Board certification could play a part in professional development across the professional lifespan. Ultimately, Tori feels she was confident enough—due to her age and other life experiences—to be successful at an internship with such a powerful role model.

Thinking back on her time with Carol, Tori feels it’s when she really learned to teach. Spending time with Carol, Tori learned the importance of meeting learners where they are and doing the same things she expects them to do. These are cognitive and behavioral actions she now implements when enacting the clinical educator role. She listens to interns so that she can adjust her clinical educator practice to their unique cognitive and behavioral needs. Tori has taken some of what she learned from Carol and found ways to make it her own. For example, rather than strictly focusing on asking “why” as a way to help novices make meaning from clinical practice experiences, which Tori perceived as sometimes too harsh, she also uses “how” questions. Tori articulated,

She’d always ask me, ‘Why, why, why.’ …I got to the point where I did not like the word ‘why’ because I felt like I just explained it to you…. She learned what I was thinking by asking that constant question. That’s how she learned about what I was processing….

I vowed I would never ask that question to my intern…and then I’ll catch myself asking why…. That was her way of getting me to start understanding what I was doing. ‘Why that approach Tori? Why did you do it that way? Why didn’t you do it this way?’ (Interview 1)

Tori believes unpacking practice through a series of how questions can be effective without being intimidating.
During Tori’s internship, the principal approached her to make the transition with him to the new, alternative school he would be leading. Though initially hesitant, Carol convinced Tori that it was a great opportunity and Tori took the position. Since it became a location where novice principals went for their own clinical practice, Tori was again in a context where clinical practice experiences were a prominent feature of the environment and shaped the school culture. Tori developed productive relationships with school leadership and was steered toward a Master’s degree in Educational Leadership. As it turned out, Tori realized that taking an administrative position wouldn’t allow her to engage in the kind of work she enjoys doing with preservice teachers. As an administrator, she would have focused more on evaluating teacher practitioners than on directly supporting novices’ learning and development.

**Professional Development**

Following in Carol’s footsteps, and concerned with improving as a professional so that she could positively impact learners, Tori decided to pursue National Board Certification. Board certification was better aligned with her professional goals and interests than becoming an administrator. She shared, “Ten years in I thought, there’s got to be something more to teaching than this. I decided to do my National Boards…. I said, ‘I just wish I could do more to reach some of these kids’” (Interview 1). While years earlier Tori thought that it was through her authentic clinical practice experiences that she truly learned to teach, she now views the Board certification process as the one that helped her hone and own her teaching. She believes this is the case because it is a professional development opportunity she felt moved to undertake and succeeded in on her own. Tori believes that becoming a National Board certified teacher underscored the importance of reflective practice—further ingraining it as a habit of mind. Additionally, it spotlighted the importance of determining whether or not one is either positively
or negatively impacting student learning—further establishing this practice as a habit of action. She recalled, “Did you impact students positively or negatively? I had to constantly ask that question to myself…. Because you can impact them negatively. I didn’t think you could…but…I realized…you can impact them negatively. Even if you’re best intentioned…” (Interview 1).

Tori recognizes that the professional development experiences she has found most powerful are the ones she has sought out on her own—born out of her self-reflective process and the subsequent awareness it yields about her unique professional development needs. She does acknowledge that each (a) understanding of the value of and (b) the drive to pursue professional development for herself are partly connected to her experiences with Carol. Despite, like Carol, having achieved many successes throughout her years as a practitioner, Tori continues seeking out professional development opportunities. Beyond serving her continued growth across the professional lifespan, it serves as a strong model of practice for the interns she works with.

Just as Tori observed Carol be a teacher leader, her interns now see her serve as a teacher leader at her school. For example, Tori spends some of her time offering professional development to other teachers. Doing this work, Tori models the importance of collaboration, being attentive to varying personalities, and the need to engage in professional development regardless of years of experience. Of importance, Tori is intentional in not only bringing novices into these experiences so that they see her serving as a leader within her “community of practice” (Lave and Wenger, 1991), but she is also mindful of the need to unpack with novices what they observe. Seeing Tori undertake such collaborative opportunities, with professionals at varying capacities, interns are better positioned to enter independent professional practice prepared to work against insular practice.
Tori wishes she could be engaged in more collaborative, professional development opportunities with interns’ colleges of education. She explained, “There isn’t any real talk about our practices as a CT…. It’s a sparkle dinner and…giving us a gift bag…. Talking…with the CTs and the universities and what has changed and what they’re looking for, we do very awful” (Interview 3). Tori is committed to improving novice practitioners’ learning experiences. Due to minimal interaction with interns’ programs, she doesn’t feel there is much she can do. For example, due to the lack of coherence in novices’ coursework, and the fact that courses don’t necessarily align with field experiences, Tori feels interns lack focus. There is too much they are trying to make meaning of at once and it is too often disjointed. Being a professional who is intent on making something productive come from all situations, Tori uses dialogue and probing questions to help novices make connections between their college of education and clinical practice experiences. She feels collaborative, professional development opportunities, between the two contexts, would contribute to her efforts and positively impact both interns’ and middle school students’ learning.

**Humble Leadership**

Humility is a personal attribute Tori is attentive to modeling. For example, if she and a novice are reflecting on why a particular lesson did not go as planned, Tori is sure to let novices know that she still has similar experiences. She believes it is important to remind them that she has been practicing for twenty plus years and still benefits from coaching: “I tell them I have a coach as well. Everybody, I think, needs a coach. Somebody to help you be a better person because nobody’s perfect” (Interview 2). Tori’s attention to humility helps novices see that one cannot become complacent with the status of their professional development and that learning must occur throughout the professional lifespan. It is not the years of experience in and of
themselves that make Tori an exemplary practitioner. Rather, throughout that span of time, she has remained humble enough to recognize that she needs to continue growing in her professional role and reflective enough to recognize in what particular areas she needs to seek additional support. By remaining humble, Tori not only makes productive relationships with interns more likely, but she also models how the trait is beneficial in her relationships with other practitioners. It is never her intent to make anyone feel lesser than. For Tori, it’s important that novices realize she has gone through, and continues going through, some of the same struggles they are experiencing.

**Not Accepting the Status Quo**

Tori works through existing barriers to her work as a clinical educator so that both interns and middle school students can experience progress. One of the biggest barriers to Tori’s work is time. She explained, “Something that hinders the process is…time. The last two years have just been meetings, which I’m pretty sure that’s going to change. I’m actually on the committee to help that change a little bit…” (Interview 2). Due to a full school day and the number of meetings Tori must attend, it is difficult to sit with novices for extended periods of time and discuss things like why particular students may not be meeting particular learning goals. However, since full school days and numbers of meetings will be parts of novices’ professional life, Tori models how to work through the constraints. She encourages novices to attend meetings with her so that they have experience seeing how faculty meetings unfold and practice exercising their professional voice in those meetings. Moreover, Tori attempts to connect what occurs in the meetings to what novices experience in the classroom. She further shared, “Time is definitely not on our side. We have to create that space…for those missed opportunities…. [I]t’s more than just meeting with them once a week…for that to be successful for them, for you, and, most importantly, for those kids” (Interview 2). Though time doesn’t necessarily work in their
favor, given structural conditions out of Tori’s hands, she models how teaching and learning occasions can still be structured, realized, and prove productive.

Tori focuses on making conditions in the professional practice context better regardless of the challenges facing her. Tori explains this way of being as one that informs all parts of her life and views herself as a progressive thinker. Said in her own words, “I’m a progressive thinker. I always want to think progressively. ‘What can we do to make it better?’” (Interview 1). Tori’s intentionality helps make it so that her efforts toward progress have a specific aim. The things she expects novices to engage in are not activities aimed at filling time. Tori believes it is important for all parties (e.g. intern; middle school students) to know what the specific aims are. When everyone involved knows the purpose of the activity undertaken, everyone is better positioned to ensure the purpose is achieved. As the clinical educator, Tori remains aware of the learning goals set for the intern and for middle school students. Being the reflective, progress driven practitioner she is, Tori strives to ingrain in novices the importance of having a purpose for practice, being open about it with learners, and circling back to it after enacted practice in order to determine whether or not that purpose was achieved. The intentionality with which she does these things is not necessarily standard clinical education practice.

**Discussing Professional Practice**

For Tori, the role of clinical educator has come to mean being a support system. Part of that system includes giving novices the mix of guidance and encouragement needed for them to move forward in their professional role. Having had one CT who left her to fend for herself, Tori believes such practice is futile because novices lack the schema to independently unpack their practice. Tori expressed, “My mission is that the classroom is open…to learn from each other, and to learn from the kids. That’s what I really would hope is the ultimate goal…so that we can go back and forth with each other” (Interview 2).
Through the coupling of their authentic clinical practice experiences and her thoughtful guidance, Tori wants novices to develop enough confidence in their professional role and practice to begin vocalizing their thoughts to other practitioners and stakeholders involved in middle school students’ education. When Tori sees that interns are willing to enter into dialogue with other members of the community of practice is when she believes it is evident that professional learning and development are being realized and they are engaged enough with the process to step increasingly more into the teacher role. By giving them guidance and support, but constantly adjusting that system, Tori aims to have novices learn to look at, interpret, and respond to their particular classroom and its particular learners. Then, novices can consider those things alongside other practitioners so that they can create and continually revise a support system for middle school students. Professional knowledge and experiences, as well as the practitioners’ confidence and willingness to dialogue with others, are important structures in that support system.

Discussing professional practice with novices, and adjusting the support system, is important when a novice has failed at his/her attempt to effectively enact a lesson. Tori sees it as her job to redirect novices’ attention away from the fact they failed and onto how practice can be revised so that middle school students’ learning is positively impacted. She expressed, “I tell them it takes time…. It’s something we will work on, and we’ll work on one thing…. There’s a lot of expectations. I’m there to support…. What do you want to work on? [L]et’s work that together” (Interview 2). It is important to Tori that novices don’t wallow in negative feelings but, rather, focus on the facts of the experience and how they can be used to make thoughtful improvements. For Tori, spending time complaining mires the practitioner down in negativity.
and occludes him/her from focusing on the ultimate goal of pedagogy: positively impacting student learning.

**Attentive to Novices’ Needs**

Though Tori works to keep novices focused on facts and on moving forward, she does not ignore their feelings. For example, Tori is aware that novices might feel ashamed after a lesson has gone wrong. She sees appropriately navigating these more emotional parts of her clinical educator role as the most difficult aspect of the work. She articulated, “Some of them are mature enough to see that. Some of the younger ones, not quite as much yet. It’s that fine line if they don’t take constructive criticism too well” (Interview 3). Rather than going directly into a debriefing session, Tori lets novices know that it’s okay for them to take some time to think about things. While she lets them know that they will have to talk about the failure, she gives them time to work through some of the emotions and meaning making on their own. Tori believes novices need guidance and is intentional in giving them guiding questions. Being respectful of novices’ feelings does not mean that their learning needs to be compromised. Just as Tori believes it is crucial to set a purpose for learning with middle school students, she believes it is crucial to help interns have a purpose for reflecting on their practice—whether that particular practice episode was successful or not.

Tori is mindful of what she views as the relationship between novices’ needs and their ages. In her experiences, the younger, traditional age interns are not as willing to articulate their rationales for particular methods to other people (e.g. the university supervisor); they have needed more guidance and support. She has found that traditional age interns are not necessarily as receptive to feedback, and she works at tempering the necessary critique with the amount of
encouragement needed to support their morale so that they are willing and able to focus on the task(s) at hand and try again.

**Evaluating Novice Practitioners**

Tori is aware that a potential barrier to novices being open and honest with her is that she has a position of power. For example, she knows that novices may hold back because she has to evaluate them. Tori does not see evaluation as a point of tension in the support system she works to create and constantly tweak. Given things like interns’ ages, phase in the professional lifespan as compared to Tori, and stakes (e.g. graduating), they perceive the situation somewhat differently. Tori is mindful of individual learner’s personalities as she works to uncover their perceptions of what will be evaluated and how they can prepare for the evaluation together. By dialoguing with them prior to a formal evaluation, Tori hopes to cut through the tension they might feel so that their attention is refocused onto middle school students’ learning. By dialoguing ahead of time, they can set the appropriate level of tension together. The dialogue Tori brings novices into after the lesson enactment is paramount to a productive evaluation. She is sure to remind them, “It’s not always going to work out your way. I tell them I’ve had these experiences as well” (Interview 2). Through debriefing how novices did on the particulars of the evaluation, they are able to decide what specific parts of novices’ developing practice need revision. Additionally, they are able to decide what points need to be added and/or rearranged in the support system—infrastructure—Tori provides so that learning and development are upheld for all members of the classroom community. In order for this complex net-work to thrive, Tori remains attentive to the tension(s) novices feel from their unique place.
Ongoing Self-Reflection

Tori’s reflective habit of mind pushes her practice forward. Working through the National Board process helped her further comprehend how reflection can help improve the professional role. Going through National Boards, and reflecting on her previous professional practice during the process, brought her to consider the following:

I remember stating that I’d like to go back to these kids and go, ‘I am so sorry. Can you come back? Come back. I’ll take you all back.’ [B]ut those first 10 years I would stand and say, ‘Just read it again. Just look at it again. Go slower.’ (Interview 1)

From the time she was an intern, it was natural for Tori to keep a diary of her experiences—one she may someday publish. Throughout work on her master’s degree she maintained a portfolio of her learning, which aided her in reflecting on how enacted practice actually lined up with particular objectives. Now, she feels that reflection is a key component of professional practice and development. She finds that modern technologies (e.g. note-taking capabilities on smartphones) make it even easier to log one’s reflections throughout the day. Tori views guiding novices’ reflections as one of her primary responsibilities because it is essential to ascertaining whether or not one’s purpose was achieved and students’ learning was positively impacted; it is an essential component of moving practice forward.

Hallmark of Professional Role

Nurturing relationships with interns, and modeling how she nurtures relationships with colleagues for the interns, is important to Tori. She believes collaboration is pivotal to successful professional practice. As interns prepare to enact a lesson Tori is sure to approach them about their plans so that, together, they can prepare for a successful lesson with their particular population of learners in mind. Because Tori has each more experience and more familiarity with her particular school context than interns, she believes that collaborating with them during the
lesson planning phase can help ensure their success, which translates to positively impacting student learning. Despite the lack of time, she is intentional in making collaboration happen by doing things like speaking with interns on the phone and/or via Skype outside of regular school hours. Tori makes sure interns see her collaborating with other English language arts teachers by doing things like bringing interns into lesson planning meetings; this way, interns can experience how the lesson planning approaches Tori uses with them are authentic to professional practice.

Tori also creates opportunities for interns to develop relationships with new teachers. She shared, “I have the preservice, the first-year teachers, and the interns on Friday afternoons in my classroom. It’s great to hear their perspectives, and I have them talk to each other” (Interview 2).

Working against insular practice, a characteristic problem in teaching, is important to Tori. She believes that when professionals come together they can join forces to ensure they are positively impacting student learning. For Tori, teaching is about collaborating and she wants to bring novices into the profession with a mindset for collaboration and the practical experience needed to enact it. She said, “It’s not just an hour. It takes a few days. It’s a constant collaboration at our teacher talk” (Interview 2). Tori is purposeful in her efforts to have novices see her and other English language arts teachers work in concert to gather data, problem solve, and goal set—all aimed at improving teaching and learning experiences for middle school students.

Given Tori’s belief that exemplary professional practice is marked by intentional, ongoing collaboration with other practitioners, a goal for interns’ learning and development is that they begin contributing to the community’s collaborative efforts. Tori does not want interns to observe community members for an entire semester. Through increasing confidence and capabilities, helped along by authentic experiences and productive relationships, Tori aims for
interns to progress into the epicenter of the community and use their teacher voice to contribute. As an ultimate goal, she looks forward to eventually learning from former interns when she sees them at District sponsored professional development meetings: “Knowing that I can meet them at professional meetings and ask them what they’re learning, what they talked about. It’s definitely refreshing to me…” (Interview 3). Ultimately, Tori aims for novices to feel empowered sharing their voice in their professional relationships.

**Conclusion**

The research question that stimulated the development of this narrative was, “In what ways does Tori make sense of her role in helping novice practitioners make meaning from authentic clinical practice?” Over the course of our interviews, it became clear that a primary concern for Tori is nurturing a positive learning environment for all learners—middle school students and interns. In making sense of her clinical educator role, Tori believes it is important she model positivity in all aspects of her professional work and show interns how to make something positive from an array of difficult situations. Tori is committed to education, and that commitment is demonstrated through the positive impact she aims to have on learners. Further, she believes she is best situated to make a positive impact on both interns’ and middle school students’ learning and development when she is attentive to their unique needs. For Tori, the clinical educator role has not come to mean that she is the sole disseminator of information. The positive impact she strives to make is best achieved through collaborative work with both learners and colleagues. Tori demonstrated that she takes pride in her work and that she’s invested in helping novice professionals grow in ways that help them develop the skills and confidence needed to carry out their work with pride and always with students’ learning as the driving force.
Chapter Summary

The preceding chapter profiled Tori so that readers gained an understanding of her before looking across the pair in the next chapter. An “I Am” poem introduced the profile, as it summarily presented the ways Tori makes sense of her clinical educator role. Details from Tori’s professionally oriented lived experiences were shared. For example, I included details from Tori’s clinical practice experiences because experiences with her cooperating teacher inform her own clinical educator role. Details from her personal intern-to-classroom teacher-transition were also included. I made clear how Tori both seeks out and offers professional development. The profile made evident how Tori thinks progressively and works to do so in collaboration with other practitioners. Collegial relationships are important to Tori, and she believes they are essential to professional practice. I also showed that Tori works to consider novices’ feelings, whether she is dialoguing with them or evaluating them. She focuses on not crushing novices’ confidence, as she wants them to come to own their teacher voice. Though she holds some positions of power, Tori remains humble and aware of each her shortcomings and need for coaching. Her continuous cycle of self-reflection helps her consider how she can improve as a professional and how she can push through potential barriers to her clinical educator work.

In the next chapter, I will look across Tom and Tori’s stories to understand the ways these two professional educators make sense of their role in helping novice practitioners make meaning form authentic clinical practice.
CHAPTER SIX: ACROSS-PARTICIPANT-DESCRIPTION

Different from the preceding profiles, each of which focused on an individual participant, this chapter looks across their stories. The goal of the chapter is to better understand “In what ways do professional educators (cooperating teachers and attending doctors) make sense of their role in helping novice practitioners make meaning from authentic clinical practice?” In this chapter, I provide an across-participant-description detailing how participants’ stories do and do not align. Headings from the previous two chapters are used, and a table is included to help organize the description.
### Table 6.1: Across Participant Alignment

<table>
<thead>
<tr>
<th>Participant Profile Heading</th>
<th>Similar</th>
<th>Dissimilar</th>
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<tbody>
<tr>
<td>Professionally oriented lived experiences</td>
<td>Participants intended on entering professions other than medicine and teaching. Experiences with other professions inform their clinical educator role.</td>
<td>Becoming a teacher was always Tom’s goal; he paid close attention to pedagogy while involved with the field of anthropology and entered medicine focused on academics. Tori was initially interested in healthcare and rejected the idea of being a classroom teacher.</td>
</tr>
<tr>
<td>Professional development</td>
<td>Both participants are intrinsically motivated to seek professional development, and they continue doing so as they progress through the professional lifespan. Both find there is a lack of professional development for the clinical educator role, and improving conditions for the populations they serve (i.e. including novices) drives their desire for development. Despite the conceptual and structural coherence issues affecting professional development in both professions, participants help make professional development possible for novices by having them work with novices at other phases of the professional education process.</td>
<td>Tom creates opportunities to engage in professional development by practicing in the community hospital setting, which differs from the teaching hospital. Due to the structure of teacher workdays, Tori is not able to teach 6-12 ELA students at different schools. For Tom, the mentorship he receives from professionals in a variety of roles is essential to his professional development and in preventing burnout. Tori views the Board certification process as the most meaningful form of professional development she has undergone. Tori is more focused on the possibility for engaging in collaborative professional development with the college of education than Tom is with the college of medicine. Tori offers formal professional development to her colleagues and does not intend on leaving her current roles; Tom is focused on developing his professional role to be a hospital wide position, which would change the way he interacts with novices.</td>
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<td>Humble leadership</td>
<td>Both participants are humble enough to acknowledge that they do not know everything about professional practice. They are intentional in letting novices know that, despite their years of experience, they still have questions.</td>
<td>For Tom, it is important to demonstrate humility by asking other practitioners questions in front of novices. For Tori, it is key to demonstrate humility by directly telling novices that she still has things go wrong when enacting the professional role.</td>
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<tr>
<td>Participant Profile Heading</td>
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<tr>
<td>Not accepting the status quo</td>
<td>Both participants are intentional in their efforts to work above the status quo, though doing so can create more work for them.</td>
<td>A lack of teaching the teachers is a problem in medical education, and Tom has created a teaching track within his residency program. While it can be easier to ignore teaching the “softer” parts of medicine, Tom works to directly address things like empathy with novices. A lack of time is a problem in teacher education, and Tori models how to work with the spaces of time that are available. Tori is open about her progressive way of thinking so that novices know that, despite barriers, she strives for progress. She further works to ensure that all members of the learning community understand the goals for practice. These divergences in what participants focus on as they work against the status quo may be connected to profession specific issues.</td>
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<tr>
<td>Discussing professional practice</td>
<td>Both participants make time outside of their regular shift/school day to engage novices in discussions about professional practice. Since both participants see it as necessary to let novices fail, they are sure to discuss those failures with them.</td>
<td>For Tom, discussions about professional practice are important because they allow him to directly address how professional practice falls off of algorithms and is concerned with processes affecting the larger system of patient care. He is intentional in orchestrating discussions about professional practice in group settings—with other specialties and during grand rounds. For Tori, offering novices support is a main feature of discussions. She helps them focus on how to make progress and aims for them to feel confident enough to discuss their professional practice with other practitioners.</td>
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<td>Attentive to novices’ needs</td>
<td>Both participants understand that by being attentive to novices’ needs they help create teaching and learning conditions that are productive toward improving conditions for either middle school students or patients.</td>
<td>Tom is particularly attentive to what has become tacit knowledge for him and the fact that much of what he knows is not yet a part of novices’ realm of knowledge. He demonstrates a sense of heightened awareness about the actions he takes in his clinical educator role and how his choices, like striking the right balance of pedagogical methods, have implications for novices’ needs. Tori is particularly attentive to novices’ feelings and views the emotionally laden aspects of her work as the most difficult. She is attentive to novices’ need for time to reflect about practice on their own but believes they need her guiding questions for meaning making to be most productive. She is aware of how novices’ ages might influence their needs.</td>
</tr>
<tr>
<td>Participant Profile Heading</td>
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<td>Dissimilar</td>
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<tr>
<td>Evaluating novice practitioners</td>
<td>Participants do not view evaluations as a barrier to productive clinical practice experiences.</td>
<td>Tom believes evaluation is overused in his residency program. However, he finds ways to productively use the data evaluations yield. Tori does not believe evaluation needs to be a restrictive point of tension, and she dialogues with novices before and after evaluations so that they understand she and the evaluations are a part of the support system.</td>
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<tr>
<td>Ongoing self-reflection</td>
<td>Both participants identify as reflective individuals; reflection contributes to their development across the professional lifespan.</td>
<td>While Tom identifies as reflective, reflective practice is not standard in medical education. For him, reflection is helpful because the professional development it spurs contributes to increased levels of confidence in varying facets of the professional role. For Tori, taking reflective notes is a daily occurrence. Though both practitioners have Board certification, the Board certification process was instrumental in Tori’s realization of how reflection can help one determine if students’ learning is positively impacted.</td>
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<td>Hallmark of professional role</td>
<td>For Tom, bringing novices into being with the multifaceted nature of the professional role is essential. For him, becoming a physician meant becoming an educator. He is intentional in having the varying facets of the professional physician’s role inform his clinical education work. For Tori, collaboration is a critical component of the professional role. She is intentional in collaborating with novices and in ensuring that novices see her collaborating with other practitioners. Her aim is that novices emerge from the clinical practice experience as active participants in the community of practice.</td>
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Study Summary

The present inquiry allowed me to study the ways two clinical educators make sense of their role. Putting their stories side by side helps demystify assumptions the individual professions may have about the other and, through looking at interview data in light of the professional formation conceptual framework, helps refocus attention on what should be understood as substantive, essential features of authentic clinical practice experiences. With regard to understanding the complexities of clinical education and those enacting the clinical educator role, each profession’s knowledge base is lacking.

While both professions cite similar goals for clinical education experiences, not enough is known about the people doing clinical education. If they don’t make sense of their role in helping novices make meaning from clinical practice experiences in ways that align with supporting professional formation, clinical education experiences may do little to prepare practitioners who work against the status quo and are intentional in their cognitive and behavioral efforts to constantly adjust the level of resistance: that is, practitioners who do more than take the path of least resistance but rather work at the ever-changing point where tension leads to progress. Progress, in the case of both professions, is always concerned with how professionals improve conditions for the populations they serve and the professional field as a whole.

Findings from this study are important because they demonstrate that the most exemplary clinical education in medicine is parallel to the most exemplary clinical education in teacher education. Despite teacher education’s longstanding interest in emulating medical education’s clinical practice experiences, no studies simultaneously look at clinical educators from both professions. It is important for those interested in reforming teacher education to understand that
exemplary clinical educators from both teacher and medical education make sense of their role in similar ways. Clinical educators from medical education don’t offer a model for teacher education’s clinical educators to emulate. Rather, these two professions have the potential to learn from one another in order to strengthen their clinical education experiences and, in turn, strengthen novices’ professional development as well as patients’ and 6-12 students’ experiences.

This study’s participants underscored existing knowledge about the influence professionally oriented lived experiences have on novices’ future professional practice. Even experiences that occurred with professions other than the ones they ultimately entered inform the ways these two clinical educators think about and do various aspects of their clinical education work. Findings underscored clinical educators as the powerful models of practice we know them to be and support the stance that both professions’ efforts to revise clinical education can neither fall flat nor be more rhetoric.

The clinical educators profiled here possess personal attributes that support their clinical education work. They infuse these attributes into their clinical education work so that the relationships they forge with novice practitioners are productive. These two professionals have thoughts and actions marked by a sense of humility, which is essential if novices are to feel comfortable sharing their uncertainties and failures. Further, they model intrinsic motivation. If novices are to enter the professional field as practitioners committed to the field’s growth and development, they must understand the essentiality of intrinsic motivation to professional practice.

These clinical educators demonstrate exemplariness and professionalism through the intentional cognitive processes marking their work. The observable things they do are first and foremost informed by careful thought. Their intentional thinking about varied aspects of their
clinical education work is always mindful of novice practitioners and either ELA students or patients. They consider particulars, such as novices’ ages. They understand and are responsive to the fact that not all novices can be approached in the same way. Their cognitive processes are always focused on moving forward, and reflective undertakings are more than reaccountments of what occurred. The intentional cognitive processes that precede their actions help mark them as professional clinical educators.

The two professionals profiled are able to articulate rationales for why they take particular actions with particular novices. A true professional’s rationale consists of more than doing what is itemized on a list of expectations. Their informed actions demonstrate attention to how and why they must approach particular expectations in particular ways with particular novices.

At the junction of these two clinical educators’ cognitive and behavioral processes are the things they have come to view as their responsibilities. Binding these processes and responsibilities together is their professional knowledge. That their professional knowledge is an essential part of the ways they think about and do their work as professional practitioners and clinical educators is significant because it helps establish the experiences they provide for novices as authentic ones.

**Conclusion**

The next chapter will include discussion of the findings. Discussion will make use of assertions and illustrative components, references to what is documented in the literature, and the study’s professional formation conceptual framework.
CHAPTER SEVEN: DISCUSSION

The present study investigated the research question “In what ways do professional educators (cooperating teachers and attending doctors) make sense of their role in helping novice practitioners make meaning from authentic clinical practice?” The study is anchored by the interest each profession has in learning from the other and the interest each profession has in improving its clinical education experiences. The study provides portraits of the ways two clinical educators make sense of their clinical educator role. Such portraits help fill a gap in the current knowledge base, which lacks in-depth accounts about what the role means and entails.

The present chapter includes assertions, which were culled by looking across the two participants’ stories; assertions are declarative statements that respond to the research question and show alignment with the definition of “role” informing this study. Each assertion is developed through illustrative components. The assertions include: (1) Professional identity is shaped by one's professionally oriented lived experiences and personal attributes, (2) Cognitive processes inform the clinical educator role, (3) Behavioral processes inform the clinical educator role, and (4) Functions of the clinical educator role are informed by cognitive and behavioral processes that are deeply connected to professional knowledge. Findings from this study show that authentic clinical practice experiences in medical education appear to share many of the same challenges teacher education is looking to rectify.

In addition to the assertions and illustrative components culled from the data, the following chapter includes a discussion of the assertions and a summary of the discussion of the research question. I then revisit the Blue Ribbon Panel’s Report and provide teacher education
some points for consideration. Following, I revisit the American Medical Association report and provide medical education some points for consideration. I additionally provide both professions, together, points for consideration. Areas for further exploration and some cautions are also shared.
Table 7.1: Assertions and Illustrative Components Culled from Data

<table>
<thead>
<tr>
<th>Assertion</th>
<th>Illustrative Component</th>
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| **Assertion One: Professional identity is shaped by one’s professionally oriented lived experiences and personal attributes** | Positive mentorship experiences
The signature feature of positive mentorship was meaningful dialogue. Having experienced such meaningful dialogue, participants articulated their understanding of using dialogue to help reveal how novices interpret particular clinical practice experiences, where miscues may have occurred, and how they need to respond. Different from Tom, Tori did not always enjoy the conversations she had with her CT. She now adapts the approaches to better suit her personality and the ways she wants to interact with interns. Tom works to help novices feel as energized by talk as he did when he worked with his mentor. |
| Clinical educator role informed by experiences with other profession | Tom had prior experience in academia and Tori in the healthcare field; these experiences have shaped how Tom thinks about teaching and learning and how Tori approaches relationship building with novices and in the clinical practice context as a whole. |
| Intrinsic motivation | Tom and Tori are intrinsically motivated to find professional development opportunities well suited for their particular needs. This is important because, beyond helping them improve as professionals, it helps them model the importance of seeking professional development across the professional lifespan. This is an important attribute to each model for and discuss with novices so that they enter the professional field prepared to do more than the status quo. |
| Seeking out more experienced others | Tom works against burn out by establishing and maintaining productive relationships with other professionals. Tori appreciates the insights an instructional coach brings to her practice. By being open about the need to learn from other professionals, Tom and Tori bring novices into their respective professions with a mindset for working against insular practice. |
| Modeling a sense of humility | Participants are open about their shortcomings, which can help novices feel okay sharing their questions and doubts. By acknowledging their gaps in knowledge and skill, Tom and Tori underscore the need to learn across the professional lifespan. |
| Being attentive to varying personalities and individuals’ needs | Tom and Tori’s personal attributes support their ability to work with a variety of learners; this is important because they are preparing novice practitioners to successfully work with a variety of either learners or patients. Tom showed himself to be aware of the varying roles novices play and how goings on related to other roles may impact their physician role. Tori showed herself to be aware of the need to approach different people in different ways so that she doesn’t compromise the opportunity to productively work with them. |
Table 7.1 (Continued)

<table>
<thead>
<tr>
<th>Assertion</th>
<th>Illustrative Component</th>
<th>Details from Data</th>
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<tbody>
<tr>
<td>Assertion Two: Cognitive</td>
<td>Goal orientation</td>
<td>Tom and Tori’s goal orientation demonstrates a progressive way of thinking. They work to ingrain in novices that professional practice must have particular aims. They are intentional in having novices set goals for their developing professional practice and helping them understand how goals connect to enactment of the professional role.</td>
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<td>processes inform the clinical</td>
<td>Creating opportunities for teaching</td>
<td>Participants’ professional knowledge allows them to comprehend where novices need additional, direct teaching and appropriately take action. They work against the general problem of missed opportunities for teaching and find ways to work within time constraints. This is an important feature of how they think about their work because novices must enter professional practice knowing that constraints are everpresent. The professional practitioner takes thoughtful actions to mitigate constraints and achieve particular goals.</td>
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<td>educator role</td>
<td>View of failure as necessary and educative</td>
<td>Tom feels it is important to let novices fail repeatedly, and he does not take over a situation unless a patient is at risk. Tori struggles with letting interns fail because she feels strongly about positively impacting middle school students’ learning. It is important that participants think about failure as a learning opportunity because they create occasions for novices to learn from their mistakes, develop their faulty knowledge and skills, and develop the cognitive resiliency to work beyond failures.</td>
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<td>Big picture and process-oriented thinking</td>
<td>The way participants approach meaning making from clinical practice experiences conveys the importance they place on helping novices understand that they are parts of a bigger system, entailing numerous processes and people. This is important to how they think about their work because they are preparing novices to enter professional fields concerned with team-based approaches to practice. Additionally, novices’ thinking must include attention to more than their immediate professional practice site.</td>
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<td>Meeting novices where they are</td>
<td>Participants’ cognitive processes entail more than strictly thinking about practice through the lens of an experienced practitioner. Tom is attentive to his own tacit knowledge, as not doing so can prevent him from effectively teaching novices about things that are not yet a part of their schema. Tori is intent on uncovering what novices are learning in college of education coursework so that she is better situated to help them bridge the two contexts. Absent such intentionality, novices’ learning stands to be compromised as teaching and learning opportunities may be either too difficult or too simplistic for their current level of knowledge and skill.</td>
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<td>Assertion</td>
<td>Illustrative Component</td>
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<tr>
<td><strong>Assertion Two (Continued)</strong></td>
<td>Novices’ ages influence their stances and actions</td>
<td>It is important that participants consider how novices’ ages might influence their cognitive and behavioral approaches because it demonstrates that they do not approach all learners in the same way. This differs from having a deficit view of younger learners. It is important that they model considering the age of the population(s) one is working with because they are preparing novices to enter professional fields where they will be responsible for helping people from varying age groups.</td>
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<td>Novices need to develop professional knowledge and language</td>
<td>Emerged from data as particularly salient for Tom, which might speak to the fact that the teaching profession lacks a codified body of knowledge and a shared language. A codified way of knowing, doing, and being guides Tom’s work. Tori remains aware of the frustrations she felt as a novice who lacked the professional knowledge and language to make sense of experiences on her own and uses that lived experience as a reminder of how important it is for her to serve as a mediator between what novices know and are able to articulate and what they need to know and be able to articulate.</td>
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<tr>
<td><strong>Assertion Three: Behavioral processes inform the clinical educator role</strong></td>
<td>Need to support novices’ morale</td>
<td>This finding held more prominence with Tori and may be connected to negative talk at her school; she is focused on providing interns with a positive experience and ensuring others’ low morale doesn’t negatively impact them. Tori views it as her mission to be a support person for novices. Tom utilizes the program’s weekly grand rounds as an occasion to jointly help novices make meaning of clinical practice experiences and collectively support their morale. Participants model how members of these two helping professions can address mistakes in ways that support progress.</td>
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<td>Gradually giving novices increased responsibility</td>
<td>Participants have the capacity to gradually give novices more control because of their unique mix of professional knowledge and personal attributes; they understand that giving novices increasing amounts of responsibility prepares them for the practitioner’s daily tasks and expands the meaning making process. Participants believe that novices must learn to “run” either the emergency department or the classroom; this is essential to how they do clinical education because, absent increasing levels of autonomy, clinical practice experiences lose authenticity.</td>
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<tr>
<td><strong>Assertion Four: Functions of the clinical educator role are informed by cognitive and behavioral processes that are deeply connected to professional knowledge</strong></td>
<td>Questioning novices to give them ownership during debriefing</td>
<td>Participants are intentional in discussing clinical practice experiences with novices, and they believe novices can come to own bodies of knowledge and their enacted practice through the kinds of questions they are asked. Bringing novices into their respective professions with an understanding of how to engage in purposeful reflection, and helping them experience how such reflection can improve their practice, is important because these habits are connected to improving conditions for either students or patients; this differs from unthinkingly doing the status quo.</td>
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<tr>
<td>Assertion</td>
<td>Illustrative Component</td>
<td>Details from Data</td>
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<td><strong>Assertion Four (Continued)</strong></td>
<td>Directing novices’ attention to data generated in practice</td>
<td>Participants see directing novices’ attention to data generated in practice as an important component of the meaning making process because it enables the practitioner to determine whether or not particular goals were met and appropriately revise practice. Not looking back to the data means attempts at each understanding and revising what occurred are based largely on assumptions. It is significant that participants see this as a part of their professional responsibility because novices may not be naturally inclined toward inquiry, may lack the know-how needed to most effectively engage in it, and likely need guidance connecting data to professional knowledge.</td>
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<td>Exposing novices to varied functions of and activities associated with the professional role</td>
<td>Participants are intentional in bringing novices into experiences enabling them to experience the whole of the professional practitioner. This differs from common occurrences in clinical education, which are marked by citing insufficient time as a reason for not participating in parts of the professional role outside of direct patient care and ELA student instruction. This approach helps ensure that novices enter independent professional practice able to affect change.</td>
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<td></td>
<td>Establishing relationships</td>
<td>Participants view it as their responsibility to help novices understand that a mix of professionals are involved in professional practice and why it’s important to forge productive relationships with them. Tom acknowledges that medicine has been ineffective at helping novices enter professional practice able to forge relationships with a variety of practitioners so that a larger portion of the patient population is positively impacted, and he works against this shortcoming by capitalizing on relationships he already has. Tori views collaboration as an essential feature of professional practice and nurtures collaborative relationships with novices. Participants’ efforts to work against insular practice are pivotal because they help ensure novices enter professional practice with a mindset for collaboration, which helps patients and students.</td>
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<td>Layered learning</td>
<td>It is important that participants help establish a collaborative mindset in novices by engaging them in collaborative experiences and discussing those experiences with them. Both detailed how they coordinate opportunities for novices at varying phases of the professional lifespan to learn from one another. They help make collaborative approaches to professional practice habits marking novice practitioners’ work.</td>
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Discussion of Assertions

Assertion One: Professional Identity is Shaped by Professionally Oriented Lived Experiences and Personal Attributes

Findings from the present study confirm that clinical educators’ prior mentorship experiences shape the type of mentorship they provide. This confirmation merits attention because preparation for the clinical educator role predominantly occurs as an apprenticeship of observation. Neither profession has thorough programs for formally preparing clinical educators. Shulman’s (2005) work on the professions advances three types of apprenticeships as a part of professional education: cognitive, practical and moral. Clinical educators should be formally prepared to think like, do like, and ethically behave like professional clinical educators. If the apprenticeship of observation is not the most effective way to transition from novice to professional practitioner, how is it an acceptable way to transition from professional practitioner to professional clinical educator?

Participants’ work is marked by humility. While literature from both professional fields documents the importance of the relationship between the clinical educator and novice practitioner, no body of literature directly addresses the clinical educator’s sense of humility as an essential feature of those relationships. Participants’ sense of humility spreads across their thoughts and actions. If the intentional behaviors they undertake are to demonstrate humility, their cognitive processes must also include humility.

The personal attribute is also connected to participants’ professional knowledge, of which practical knowledge is a component. As a part of their professionally oriented lived experiences, they have come to know humility as an important feature of the relationship between novice practitioner and clinical educator if productive meaning making and novice professional development are to transpire. Addressing humility during clinical practice experiences, Russell
and Martin (2013) note that “Helping people learn to teach is not about demonstrating how much we know about teaching; helping people learn to teach is about putting our own on-going professional learning at the service of those just beginning the required unlearning, learning and relearning” (p. 226). However, they do not delve into how to make sure humility is an attribute clinical educators possess and specific ways it can be helpful in the “unlearning, learning and relearning” novices must engage in with the guidance of their humble clinical educator.

Jochemsen-van der Leeuw, van Dijk, van Etten-Jamaludin, and Wieringa-de Waard’s (2012) review of the literature identified humility as an important attribute for the clinical educator to possess. While they document that tools exist for clinical educator evaluation, there is no mention of tools for clinical educator selection. Rather than primarily focusing on evaluating current clinical educators, including their demonstration of an attribute like humility, it is important to understand how practitioners who possess humility can be selected for the clinical educator role and provided with professional development that will help them ensure humility is a feature of their work.

Present models for doing clinical education fall short because they assume that proficient practitioners can simply do the listed behaviors (McGee & Irby, 1997; Neher et al., 1992). Though participants were fortunate to have had exemplary role models, their exemplariness does not entirely stem from those experiences. Showing the intrinsic motivation needed to further develop as professionals, participants sought out professional development that would help them sharpen the ways they think about and do clinical education so that they could better serve novice practitioners and either 6–12 students or patients. Ryan and Deci (2000) define intrinsic motivation as “the doing of an activity for its inherent satisfaction rather than for some separable
consequence. When intrinsically motivated, a person is moved to act for the fun or challenge entailed rather than because of external products, pressures, or rewards” (p. 56).

There is no body of literature specific to the clinical educator’s intrinsic motivation. Given that the clinical educator is a powerful influence on the novice practitioner, it warrants further understanding how the clinical educator’s intrinsic motivation might influence the novice’s intrinsic motivation during clinical practice and beyond. Kusurkar, Roiset, Mann, Custers, and ten Cate (2012) note that the following are critical features for supporting learners’ intrinsic motivation: “autonomy support, adequate feedback, and emotional support” (p. 735). While the two clinical educators profiled here offered these things to novice practitioners, the study points to a gap in who is supporting clinical educators’ intrinsic motivation. It is essential to develop systems for offering clinical educators “autonomy support, adequate feedback, and emotional support” so that they, in turn, do the same for novices.

**Assertion Two: Cognitive Processes Inform the Clinical Educator Role**

The cognitive processes participants move through are intentional and aligned with the professional formation conceptual framework. Through the cognitive processes they set in motion, participants instantiate a progressive way of thinking that is necessary for supporting novices’ professional development and improving conditions for the populations they serve. Their cognitive processes include both looking back and focusing on the present in order to make the best decisions about moving forward.

Intentional, purposeful reflective practice is an important cognitive process. Reflective practice is well documented in the teacher education literature, and expecting preservice teachers to engage in reflective practice is common; this is not the case in medical education. This study’s participants identify as reflective individuals, engage novice practitioners in reflection, and
demonstrate an understanding of purposeful reflection. It is purposeful because it is not solely a reporting of what happened. When they look back on enacted practice, they do so with the intentions of making meaning, adapting practice, and improving conditions for the populations they serve. Though neither profession has necessarily mastered the use of reflection, this is an area where teacher education can contribute to medical education. Medical education stands to learn from teacher educators who masterfully use reflection, and they can adapt teacher educators’ approaches for meaningful use in the medical education context.

The teacher education literature includes work documenting the importance of noticing. This serves mentioning here because one can reflect on what one notices. Both participants demonstrated that they help novices learn what is important to notice, as knowing what to notice is not wholly intuitive. Novices tend to notice things about their own practice but not how those things connect back to either students or patients. In the medical education literature, noticing includes being able to monitor one’s “own actions, curiosity to examine the effects of those actions, and willingness to use those observations to improve behavior and thinking in the future” (Epstein, Siegel, Silberman, 2008, p. 5). In the teacher education literature, using part of van Es and Sherin’s (2002) definition, Star and Strickland (2007) define noticing as “identifying what is important or noteworthy about a classroom situation” (p. 111). Preservice teachers, they contend, are not able to independently identify what is important and noteworthy and need the clinical educator’s guidance.

In order to realize its potential as a part of how clinical educators support novices’ development of professional formation and reform minded practice, the intentional act of noticing needs more attention in both professional contexts. van Es and Sherin (2008) “argue that in the context of reform, noticing is a skill that teachers may need to develop further” (p. 245). In
both contexts, using video has gained some prevalence as a way to help novices learn what to notice. This study shows that there is a gap in teaching clinical educators what to notice. If clinical educators are to prepare novices who know what to notice, have the capacity to connect their noticings to professional knowledge, and are able to transform what is learned into mindful adaptations and/or reform oriented actions, they must first be taught how to notice as clinical educators. Then, they must know how to meaningfully relay their noticings to novices. It may be that video is a productive way to teach clinical educators what they must be intentional in noticing.

Clinical educators must have ownership of Shulman’s pedagogical content knowledge, which takes special and ongoing preparation currently lacking in both professions. While this study does not provide a definitive answer, it might be that clinical education is more likely to be improved when it has its own bodies of pedagogical knowledge, content knowledge, and pedagogical content knowledge. Then, clinical educators might be better positioned to know how to teach novices, what to teach (e.g. what to notice), and how to best make content known to a variety of adult learners in varied professional practice contexts. Developing a clinical-educator-specific body of pedagogical knowledge presents another opportunity for teacher educators, experts in pedagogy, to help medical educators.

The intentional cognitive processes marking participants’ clinical education set it apart as exemplary (Feiman-Nemser, 2001; Giebelhaus & Bowman, 2002). The ways they think about their work align with what Feiman-Nemser termed “educative mentoring,” which “promotes beginning teacher development by cultivating a disposition of inquiry, focusing attention on student thinking and understanding, and fostering disciplined talk about problems of practice” (p. 28). In the medical education context, the “educative mentor” focuses novices’ attention on the
best course of treatment for the patient. In order to make these things regular parts of their clinical educator practice, participants did not leave things to chance.

Participants cognitively focus on the two populations they serve: novice practitioners and either students or patients. They provide educative mentoring because they (a) help make clear how novices’ actions must be informed by intentional thoughts focused on either students’ or patients’ needs and (b) help novices discuss certain needs as problems of practice to be studied and acted on. While the teacher education literature includes some work profiling “educative mentorship,” the work tends to focus on the induction years of teaching (Giebelhaus & Bowman, 2002). In the medical education literature, there is scant work profiling the cognitive processes attending physicians undertake. It is notable that this study profiles “educative mentoring” occurring during the preservice years and in the medical education context.

In closing, if particular cognitive processes are not a part of the clinical educator’s work, what sets the clinical educator apart as a professional clinical educator in a particular profession? By making particular cognitive processes a part of being a clinical educator, the clinical educator helps ensure that s/he’s preparing novices to enter the professional role with ownership over the ways of thinking that mark him/her as a professional practitioner in a particular field.

Assertion Three: Behavioral Processes Inform the Clinical Educator Role

The ways that participants describe their clinical educator role align with the stance that the role entails more than doing certain behaviors (Cooke, Irby & O’Brien, 2010). Behaviors must be intentional and informed by cognitive processes. In becoming and being an exemplary clinical educator, one progresses through a process of “dynamic self-congruence” (Higgs & McCallister, 2007) so that knowing and doing the profession are parts of the whole. This study elucidates that the process of dynamic self-congruence holds true for clinical educators from
teacher and medical education, which helps demystify medical education’s clinical educators as the ones to emulate.

Both participants demonstrated that some of their clinical educator behaviors should be done alongside other practitioners, which aligns with the collaboration both professions claim they want to see in clinical education (AMA, 2007a; Josiah Macy Jr. Foundation, 2010; NCATE Blue Ribbon Panel on the Transformation of Teacher Education through Clinical Practice, 2010). Both pay attention to supporting novices’ morale and showed intentionality in enacting their supportive behaviors with other emergency medicine physicians or English language arts teachers.

The construct of resilience has not been widely studied in either profession’s clinical education. In supporting novices’ morale, clinical educators’ mindful behaviors help strengthen novices’ resilience. Howe, Smajdor, and Stockl (2012) note that resilience has “physiological and psychological” dimensions and can be understood as “flexible adaptability in the face of challenge, which can be recognized in both individuals and social groups” (p. 350). The way participants support novices’ morale and resilience aligns with the stance that strengthening resilience is marked by a focus on support, not a deficit view of a particular population (Howe et al.). Still, they create challenging learning situations for novices to work through, and some work on resilience shows that “challenging experiences assist the development of resilience” (Rutter, 2006, as ctd. in Howe et al., p. 351). Clinical education in both professions presents an ideal time to focus on supporting novice practitioners’ resilience because clinical educators are present to create and monitor challenging experiences (Howe et al.). Resilience warrants attention in both professions’ clinical education.
Clinical educators must be adept at enacting behaviors that nurture novices’ resilience because they must help novices (a) understand that their thoughtful behaviors can improve conditions for either students or patients, (b) engage in reform minded practice with the potential to improve the professional field, and (c) grasp the importance of taking the actions necessary to avoid leaving the profession due to difficult circumstances. Building a resilient workforce is an essential part of developing a strong, sustainable professional field, and clinical educators are an important part of this building process. It makes sense that the clinical-educator-selection-process gives attention to how clinical educators demonstrate resilience in their own professional practice.

Participants from this study enact behaviors that are productive toward gradually giving novices increased autonomy, which is important because the literature shows that clinical education experiences are often marked by missed opportunities for teaching and learning (Borko & Mayfield, 1995; McGee & Irby, 1997; Neher et al., 1992; Valencia et al., 2009; Yardley, Brosnan & Richardson, 2013). Obviously, a good portion of the learning during authentic clinical practice must come from novices experiencing autonomous enactment of the professional role. Data from this study show that strengthening novices’ resilience is connected to clinical educators’ behavioral processes because graduated levels of autonomy can support resilience (Howe et al., 2012).

This study shows that clinical educators from both professions wrap around the issue of how much to step in and assist novices as novices step further into the professional role. As noted by Howe et al. (2012), there must be “less didactic” approaches during professional education (p. 352). Further, novices must be given thoughtful feedback on performance; the feedback should support autonomy and resilience because it is productive in novices’ learning
“to use feedback to build confidence and strengthen their own performance” (p. 352). Clinical educators must understand the connection between autonomy and the development of resilience and how their behaviors can be influential in supporting both.

This study is partly anchored by the professional formation conceptual framework. A part of professional formation is being a professional who makes thoughtful contributions to the professional field. Howe et al. (2012) articulate that “Giving students some choice and control over aspects of their learning mirrors mechanisms that engender beliefs in one’s ability to influence the ‘system’” (p. 353). Given the connection between field building and autonomy, both professions’ should be concerned with appropriately giving novices autonomy if they are focused on preparing them to contribute to the profession’s growth and development.

**Assertion Four: Functions of the Clinical Educator Role are Informed by Cognitive and Behavioral Processes and Deeply Connected to Professional Knowledge**

Swanwick’s (2014) question of “what do we mean by a professional in the 21st century” was previously shared, and data reveal that participants make sense of their role to mean that they are *professional* clinical educators. Their intentionality in using professional knowledge as a driving force for carrying out functions of their role makes particular cognitive and behavioral processes habits of mind and action for them. “Habits of thought, feeling, and acting” underpin professional formation (Wear & Castellani, 2000, p. 603). Their role modeling and their intentionality help strengthen novices’ professional formation. Professional formation is connected to this assertion because the ways these clinical educators help give novices ownership over their practice, direct novices’ attention to data generated in practice, expose novices to the broad range of activities connected to the professional role, and engage novices in collaborative practice support professional formation.
Current literature demonstrates that selection criteria most frequently focuses on novice practitioner selection. The absence of selection criteria for clinical educators means that clinical education is vulnerable to being carried out by practitioners who lack the capacities to discuss the ways they think about and enact their work with mindfulness toward professional formation. This mindfulness is always concerned with achieving “excellence across the domains of practice” so that conditions of the populations they serve are improved (Cooke, Irby, & O’Brien, 2010, p. 38).

In light of the study’s small scope, it highlights shared shortcomings in both professions’ clinical education. Clinical education is too frequently characterized by insularity: one clinical educator working with one novice practitioner. Actions must be taken, and guidelines for practice set in place, so that clinical education can be marked by thoughtful, sustainable collaboration among professional practitioners, novice practitioners, and clinical educators. Teacher education cannot simply state it wants to emulate medical education’s clinical practice teams; these teams are not the norm.

**Summary of Discussion of Research Question**

The ways participants make sense of their clinical educator role emanate from the whole of who they are and underscore the complexity of the role. This has implications for who should do clinical education and what professional development programs specific to the role should entail.

The study underscores that the apprenticeship of observation is not how one should learn to do clinical education. Clinical educators should possess certain personal attributes. Both humility and intrinsic motivation are important and understudied ones. In neither teaching nor
medicine is clinical education immune to clinical educators’ background experiences and personal attributes.

Reflective practice showed itself to be an area where teacher education can contribute to medical education. Reflection must be purposeful because it is concerned with making meaning so that professional practice and conditions for the population(s) served are improved. Reflection and noticing go hand in hand, and more attention must be given to what clinical educators ought to notice. Developing clinical-education-specific bodies of knowledge could be helpful in preparing both professions’ clinical educators to provide “educative mentoring” (Feiman-Nemser, 2001b). Reflection, noticing, and educative mentoring entail intentionality in the cognitive processes marking clinical educators’ work.

Participants’ behavioral processes also showed themselves to be marked by intentionality. They are intentional in supporting novices’ morale, which can strengthen novices’ resilience. Novices are then better positioned to enter independent professional practice on a course to persist through problems of practice. It is essential to understand how to best support clinical educators’ morale and select clinical educators who demonstrate resilience.

Both participants view it as their responsibility to work against insular practice, which is problematic in both professions. Collaborative practice is important to professional formation. Clinical educators must demonstrate a commitment to professional formation if they are to make its development in novices a driving force of their clinical educator practice. Without clinical educator selection criteria and professional development, these things are left to chance.

Professional formation served as the study’s conceptual framework. Though participants did not use the term “professional formation” to capture the ways they make sense of their role in helping novices make meaning from clinical practice experiences, their articulations
align with the construct. Their capacity to support professional formation comes from their ownership of a special mix of cognitive and behavioral processes, professional knowledge, and personal attributes. In the coming together of these things, they create teaching and learning opportunities focused on supporting the coalescence of theoretical and practical knowledge (Feiman-Nemser, 2001; Grossman et al., 2008; Korthagen & Kessels, 1999), an inquiry stance toward practice (Cochran-Smith & Lytle, 1999), and the reform mindedness (Feiman-Nemser; Swick, 2000) needed for field building (Cooke, Irby, & O’Brien, 2010; Turner, Palazzi, Ward, & Lorin, 2012).

Findings from this study corroborate findings in the literature that there is a lack of consensus about what the clinical educator role entails (Harden & Crosby, 2000; Veal & Rikard, 1998). Without a shared, agreed-upon understanding of what the role entails, the following are not possible: creating standards for clinical educator practice, providing professional development opportunities aimed at helping clinical educators reach those standards, or ensuring that novices get “fair” opportunities during authentic clinical practice experiences instead of “the luck of the draw.” Absent an understanding of the clinical educator role, an understanding that can be reached in part by uncovering the ways clinical educators themselves make sense of their role, neither teacher nor medical education has any real way of uniformly and thoughtfully selecting clinical educators.

Revisiting the Blue Ribbon Panel Report

The present study profiles two exemplary clinical educators. At the onset of this study, I articulated that teacher education does not appear to have a deep enough understanding of medical education from which to derive changes in teacher education. I also referenced NCATE’s Blue Ribbon Panel’s Report (2010). The Panel suggests revising teacher education’s
clinical practice experiences to look more like medicine’s by ensuring that novice teachers, like novice physicians, are guided through clinical practice experiences by expert clinical educators.

Interviews with the attending physician affirmed what is documented in the medical education literature: clinical practice is frequently guided by people who (a) are neither carefully selected nor prepared for the role and (b) receive minimal support for the work. Before modeling teacher education’s clinical practice experiences after medicine’s, it is crucial to more fully understand both what is right and what is wrong with medicine’s clinical education. Then, teacher education would be better poised to thoughtfully collaborate with medical education and make improvements to both professions’ clinical practice experiences.

The present study reveals that clinical educators don’t necessarily have the “special expertise” (p. 20) the Panel deems important. Participants’ expertise has predominantly come from professional development opportunities they’ve sought on their own. If the two professions are truly committed to improving clinical education, clinical educators must be more like the two profiled here. Clinical educators like these participants cannot be the exception if novices are to enter professional practice with the habits of mind and action that will help them seek improvement across the professional lifespan because they are invested in (a) improving conditions for either students or patients and (b) building the professional field.

The Panel asserts that “New teachers need more than technical skills” (p. 9). The same holds true for clinical educators. Participants demonstrate that enacting the clinical educator role in exemplary ways entails more than attention to technical skills. If the Panel’s goal of having preservice teachers “have opportunities to reflect upon and think about what they do, how they make decisions…and how they integrate their content knowledge and pedagogical knowledge into what they do” (p. 9) is to be realized, more attention must be given to understanding the
clinical educator role and ensuring that clinical educators have the capacity to make the aforementioned take place and are supported in their efforts. As stated by this study’s participants and the Blue Ribbon Panel, clinical education should not be marked by the luck of the draw.

The Panel suggests that clinical educators should be “exhibitors of the skills of clinical educators” (p. 6). The present study and both professions’ literature indicate that what these skills are remains unknown. If clinical educators are to be carefully selected, partly based on their ability to exhibit a particular skills set, it’s important that we continue work aimed at identifying the clinical educator’s skills set. Participants demonstrate some of the skills essential to exemplary enactment of the clinical educator role. It’s important that individuals and organizations with the necessary resources carry out large-scale studies in order to more fully understand the skills clinical educators deem necessary in order to effectively carry out the work.

**Teacher Education: Points for Consideration**

In some ways, stepping into the important role of cooperating teacher is marked by the same kind of trial by fire as stepping into the role of intern/novice practitioner. Changes must occur so that cooperating teachers are better prepared for the important work they undertake. The complexity of clinical education work calls for more thorough preparation than can be provided in a brief workshop. To be clear, developments in the field of mentoring are occurring; additionally, teacher education has seen both an emergence of hybrid educators and effective examples of clinical education taking place in professional development schools. Effective examples of clinical education and extensive clinical educator preparation, however, cannot be the exception (Feiman-Nemser, 2001b). Just as being a content area expert does not mean one
can proficiently teach the content, being a highly effective secondary English language arts teacher does not mean one can teach adult learners how to teach secondary English language arts.

A comprehensive preparation and continuous development program for cooperating teachers should borrow elements from the certification process used by the National Board for Professional Teaching Standards. As with National Board certification, cooperating teachers should have to demonstrate ongoing achievement and excellence in their clinical educator practice. Every five years, cooperating teachers should provide evidence demonstrating their efforts to positively impact interns’ professional development. There could be formal evaluations at the same five-year mark.

**Revisiting the American Medical Association Report**

Medical education is also interested in revising conceptual and structural conditions for the preparation of our Nation’s physicians. As noted elsewhere in this document, The American Medical Association (2007) composed an *Initiative to transform medical education*. Their work continues today, and the Association has awarded millions of grant dollars to eleven medical schools that submitted proposals with innovative plans for transforming various features of medical education. The Association’s reports and ongoing initiatives make clear that, while there are things teacher education can learn from medical education, the medical education field is not full of expert clinical educators. In fact, providing more and better professional development for clinical educators is a part of what the Association is working to improve.

One of the recommendations made in the Association’s report is giving more attention “to characteristics of applicants that predict success in the interpersonal domains of medicine [and to use] valid and reliable measures to assess” them (p. 2). Given that clinical educators are strong models of practice, it is also important to consider these things when selecting
practitioners for the role. Clinical educators must embody, model, and know how to discuss interpersonal domains of medicine, such as humility, with novice practitioners. Selecting medical students who are humble is not enough in the work to transform medical education. The Association does acknowledge that, in addition to learning from the “formal curriculum…trainees also learn from faculty role models” (p. 3). In order to confront the hidden curriculum, clinical-educator-selection criteria must be put in place.

Educators in the medical education context stand to benefit from what exemplary teacher educators have to offer. One of the Association’s recommendations includes extending medical school admission requirements to include coursework in the social sciences. While there are some initial examples of this taking place, it is important to provide clinical medical educators with courses on pedagogy. Here, college of education faculty can offer residency program faculty valuable lessons. East Carolina University’s Brody School of Medicine has partnered with the University’s College of Education. Through this partnership, education faculty help medical educators learn how to both create and improve curricula. Faculty from colleges of medicine and education should forge relationships with one another, and forging these interprofessional relationships should be a feasible goal on campuses where there are both colleges of medicine and colleges of education.

The Association does recommend that the cadre of medical education faculty be broadened “to include individuals with important new content expertise (for example…social sciences)” (p. 3). This presents an opportunity for teacher education to pursue partnerships with colleges of medicine and residency programs. While the teaching profession does not enjoy the privilege of being considered an upper profession, teacher educators should take pride in the expertise they can offer medical educators. The teacher education field is replete with model
teacher educators who are able to meaningfully share pedagogical expertise. Medical education has identified their need for pedagogical expertise, and it is upon us to make systemic efforts to help them meet it.

Like novice practitioners, clinical educators must also be evaluated on their practice. The Association notes that methods used for evaluation should strengthen, “not stifle, needed educational innovation and change” (p. 3). When novice practitioners see how thoughtful evaluation, coupled with meaningful feedback, can be productive toward continued professional development and formal study of problems of practice, they are likely to be more receptive to the evaluations that they must undergo. This is important because if novices are closed off to evaluation and feedback, their developing practice may be stifled. Ongoing evaluation of clinical educators should serve as a source of professional renewal and development. Neither profession can blindly trust that these powerful models of practice masterfully enact the role for the entirety of their time in it.

**Medical Education: Points for Consideration**

Many residents go directly from residency training to working as attending physicians; this transition means that they immediately take on the clinical educator role with little to no preparation for stepping into the role of the teacher. Beginning at the residency level, medical education must do a better job of identifying potential teachers. These novices should progress through extensions of their residency program aimed at helping them (a) decide whether teaching is for them and (b) develop the multifaceted clinical educator role. It speaks poorly of how education is viewed within a profession if minimal attention is given to preparing those who will do education.
Additionally, there must be professional development opportunities specific to clinical education. It is important to acknowledge that there are features of clinical education that make it different from teaching in the undergraduate medical education classroom. While clinical educators should be intrinsically motivated to seek out professional development opportunities suited for their unique needs and their particular place in the professional lifespan, participating in clinical-education-specific professional development should also be a requirement. Teacher educators, from the teaching profession, could play an important part in these professional development opportunities.

The Two Professions: Points for Consideration

Standards for practice ought to be put in place for each the thoughtful selection and continuous support of clinical educators. Not implementing such standards implies that authentic clinical practice experiences are not that important to novices’ learning and development, have little impact on how novices enter independent professional practice, and are experiences novices can make productive meanings of independently.

Both professions have some level of screening for potential novice practitioners before they are admitted to the professional school. Certain programs do an exceptional job of offering their novices continuous support. Screening and support measures should be extended to clinical educators. It is counterproductive to carefully select candidates but ignore careful selection of and support for the professionals guiding those candidates through clinical practice. Clinical educators should have to meet particular requirements (e.g. being Board certified), move through a rigorous interview process (e.g. involving a mix of administrators, practitioners, and other clinical educators), and demonstrate (e.g. through the use of audiovisual evidence) that they
continue working to positively impact both novice practitioners and all members of their community of practice.

This undertaking would be a marked shift in the clinical education landscape and would require a great number of resources. But ignoring careful selection of and support for clinical educators puts stressors on the entire system of either healthcare or education because clinical educators play a role in shaping the profession’s newest members. Both professions must develop interview instruments, organize interview committees and processes, and design educational programs for the initial preparation and continuous professional development of clinical educators.

**Areas for Further Exploration**

Future studies could include more participants from each professional field. The two participants in this study are exceptional clinical educators in a number of ways. It would be useful to see if other participants, selected with attention to the same criteria, make sense of their clinical educator role and the ways they help novices make meaning from clinical practice experiences similar to or different from Tom and Tori. It would also be useful if future research included the novice practitioners clinical educators work with. In this way, findings from interviews with the novices could be compared with what clinical educators revealed. This could be helpful in efforts to better understand and improve clinical education because if educators and learners have markedly different perceptions of what is happening in the learning environment they are less likely to have a “productive joining of forces” (Feiman-Nemser, 2001a). There must be a level of congruence in what educators and learners identify as their goals for practice so that they can work collaboratively and truthfully to achieve those goals and positively impact the populations they serve.
There must be further exploration into developing tools for thoughtfully selecting clinical educators. Some selection tools are already in use for screening potential teacher and physician candidates, and these can be used as starting points. If it takes a special kind of expertise to be an effective clinical educator, and the practice of clinical education differs from the more general practicing of the profession, it makes sense that different tools be used for the thoughtful selection of the profession’s clinical educators. Each field must further explore exactly what the clinical educator’s unique attributes and abilities are so that appropriate selection tools are developed.

There is a need for clinical educator specific professional development. Since clinical education is different from practicing the profession of either teaching or medicine, and practicing the profession calls for professional development, it makes sense that there be professional development for the practice of clinical education. It is important to further explore what the content of such professional development should be. It should also be explored how professional development is best aligned with a clinical educator’s place in his/her clinical-educator-professional-lifespan. Additionally, it would be helpful to explore how worthwhile and effective clinical-educator-specific professional development programs prove themselves to be. The preceding can be accomplished by following up with participants themselves and gathering the perceptions of the novice practitioners they work with.

The present study made use of the professional formation conceptual framework. The framework’s relationship to clinical education merits further exploration. Given the stance that professional formation is the ultimate goal of professional education, it would be meaningful to explore how clinical educators enact their role if they receive explicit instruction on professional formation and how to most thoughtfully thread its tenets through their work. Longitudinal work
on how careful attention to professional formation influences novices’ professional practice is needed.

Cautions

Interviews served as the only source of data. However, this aligns with the in-depth phenomenological interviewing method (Seidman, 2013). I trusted that participants were open and honest with me throughout our series of interviews, and I believe the study’s selection criteria helped ensure that participants were people invested in the work.

The use of Skype, for the interviews with Tori, might be seen as a limitation. However, Tori demonstrated proficiency in her use of technology and she felt comfortable speaking with me through the program. Since Skype allowed us to see each other, I remained attentive to her facial expressions and body language.

Conclusion

While some of the study’s findings confirmed things we already know, the study shows that aspects of the clinical educator role cut across the two professions. This is a significant finding given teaching’s longheld interest in modeling its professional education processes after medicine’s.

Participants’ work with novice practitioners, and either middle school students or patients, is driven by the desire to improve conditions for those populations, which aligns with professional formation. Data show how a combination of intentional cognitive and behavioral processes, along with personal attributes, comes together to inform the clinical educator role. It is significant that clinical educators from the two professions approach professional formation similarly. Further, both professions must begin accounting for the clinical educator’s habits of
mind and action, along with personal attributes, which can either strengthen or weaken authentic clinical practice.

Findings point to the need for a thoughtful clinical-educator-selection process and the creation of clinical-educator-specific professional development programs. Marking these two participants as exemplary clinical educators is the intentionality with which they think about and do their work. Their intentionality helps their habits of mind and action positively impact, beyond their clinical educator destiny, the populations of either students or patients and novice practitioners they are committed to serving.
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APPENDICES
## Appendix A: Literature Review Organization Table

### Table A.1: Literature Relevant to the Clinical Educator Role and Meaning Making

<table>
<thead>
<tr>
<th>Source</th>
<th>Text Type</th>
<th>Contributions to Understanding Role of Attending Physician in Clinical Practice</th>
<th>Review Section</th>
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<tbody>
<tr>
<td>Harden &amp; Crosby (2000)</td>
<td>Theory</td>
<td>The authors note the lack of understanding surrounding the changing and complex role of the teacher. Grounded in the belief that students’/novice practitioners’ learning and development are compromised if the teacher is ineffective, the authors provide a descriptive framework for looking at twelve roles of the medical teacher. If the roles are not understood, efforts to each improve and reward teaching will be thwarted. Authors gave a questionnaire (N=251) to medical educators as a means for supporting (or not) their identified roles. Roles were conceptualized as “responsibilities of a teacher” (p. 336).</td>
<td>Role of Clinical Educator in each Medical &amp; Teacher Education</td>
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<tr>
<td>Skeff (1988)</td>
<td>Theory</td>
<td>Underscoring the importance of paying attention to clinical education, as the complex and vast system of healthcare changes, the author offers a conceptual framework useful in each the analysis and development of clinical teaching. The seven, interrelated components of the framework are learning climate, control of the teaching session, communication of goals, understanding and retention, evaluation, feedback, and self-directed learning. A definition is provided for each component, as well as its relationship to “teaching effectiveness.”</td>
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<td>Litzelman et al. (1998)</td>
<td>Research</td>
<td>In order to validate and potentially simplify a commonly used framework for the evaluation of clinical educators, the authors used a split sample (N1=93; N2-85) of 1,581 medical students’ evaluations of their clinical teachers. Identifying a need for quantitative methods to validate the seven-category SFDP Framework, factor analysis was employed. Findings added validity to the framework, revealed students’ perception of teachers’ content knowledge and ability to encourage self-directed learning as a single category, and contributed a simplified evaluation tool for students and residents.</td>
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<tr>
<td>Neher et al. (1992)</td>
<td>Theory</td>
<td>The authors build on previous studies, which have identified clinical teaching in the outpatient setting as particularly challenging due to challenges like time constraints. Their work also builds on the well-documented problem that medical clinical educators rarely have any formal, educational training. Similar to the majority of the research into the role of the clinical educator, their work focuses on observable behaviors. They provide a five-step model that clinical educators can both learn and apply quickly.</td>
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<td>Hesketh et al. (2001)</td>
<td>Theory</td>
<td>The authors support an outcome-based model of education and offer an outcomes-based framework for preparing doctors to enter their multidimensional role of teacher. Their 12-outcome-framework includes the teacher’s ability to demonstrate competence in clinical teaching, service to the profession and community, and commitment to professional development across the professional lifespan. They suggest the framework also be used by medical educators to self-assess and plan for professional development accordingly. They acknowledge the framework has limitations and encourage contributions to its refinement.</td>
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<td><strong>Research</strong></td>
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<td>The authors identify the challenges and potential located in clinical teaching that</td>
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<td>is situated within the ambulatory/outpatient setting. Though it is documented that</td>
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<td>clinical teachers in the outpatient setting have minimal windows of time for teaching,</td>
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<td>it is also the case that their role modeling can both positively and negatively impact</td>
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<td>learners’ developing practice. They suggest that in order to maximize their ability</td>
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<td>to teach effectively, educators tend to the following areas: setting and being explicit</td>
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<td>about expectations, asking questions as a form of formative assessment, modeling</td>
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<td>particular tasks, behaviors, etc., providing constructive feedback, and engaging</td>
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<td>novices in reflection.</td>
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<td>Wright &amp; Carrese (2002)</td>
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<td><strong>Research</strong></td>
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<td>That clinical educators serve as role models for novice practitioners is widely</td>
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<td>documented. The authors used in-depth interviews (N=29) to gain clarity on role</td>
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<td>modeling from the perspective of physicians who have been identified as respected</td>
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<td>role models. Participants revealed characteristics under the categories of “personal</td>
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<td>qualities” and “teaching” related to role modeling. Role modeling was found to be a</td>
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<td>mix of personal, pedagogical, and clinical skills that can be learned and/or refined.</td>
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<td>Proctor (2010)</td>
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<td><strong>Research</strong></td>
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<td>Identified three roles, or “aspects,” of supervision: normative, formative, and</td>
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<td>restorative. Respectively, those are connected to standards, professional development,</td>
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<td>and what practitioners need in order to remain committed to the field.</td>
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<td>Steinert (2014)</td>
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<td><strong>Research</strong></td>
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<td>Due to the lack of a common understanding about what the term “medical educator”</td>
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<td>means, semi-structured interviews were used as a method for gathering information</td>
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<td>about how medical educators (N = 12) think about and define their role. Common among</td>
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<td>participants’ conceptualizations were a commitment to reflective practice and</td>
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<td>innovation.</td>
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<td>Higgs &amp; McCallister (2007)</td>
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<td><strong>Theory</strong></td>
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<td>The qualitative study employed a hermeneutic phenomenology and narrative inquiry</td>
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<td>methodology. Five speech pathologists, who are also clinical educators, were</td>
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<td>interviewed and stories were created to represent their experiences of “becoming and</td>
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<td>being” (p. e51) clinical educators. A model of “The Experience of Being a Clinical</td>
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<td>Educator” was created and its six dimensions include: sense of self; sense of</td>
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<td>relationship with others; sense of being a clinical educator; sense of agency;</td>
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<td>dynamic self-congruence; experience of growth and change.</td>
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<td>Kilminster &amp; Jolly (2000)</td>
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<td>The authors identify clinical supervision as an important and understudied feature</td>
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<td>of graduate medical education. They conducted a literature review in order to tease</td>
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<td>out characteristics of “effective supervision.” Supervision literature from</td>
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<td>teacher education was included. Their findings suggest that the relationship between</td>
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<td>supervisor and novice practitioner is more powerful than the instructional methods</td>
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<td>used. They call for more studies into clinical supervision so that frameworks for</td>
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<td>practice can be developed and used.</td>
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<td>Irby (1994)</td>
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<td><strong>Research</strong></td>
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<td>The author’s work was driven by the need to identify the knowledge bases requisite</td>
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<td>for exemplary clinical teaching and, following, create a model of it. Using a case</td>
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<td>study methodology (N=6), the author set out to uncover the knowledge bases “distinguished</td>
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<td>clinical teachers” draw on during teaching rounds. Shulman’s work on pedagogical</td>
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<td>content knowledge helped inform the study. Irby explicitly stated the “apprenticeship</td>
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<td>of observation” is how the exemplary participants learned to teach.</td>
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<td>Table A.1 (Continued)</td>
<td><strong>Contributions to Understanding Role of Cooperating Teacher in Clinical Practice</strong></td>
<td><strong>Contributions to Understanding of Meaning Making in Medical Education</strong></td>
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<td>Veal &amp; Rikard (1998)</td>
<td>Studying the triad from the cooperating teacher’s perspective, authors found that CTs are more influential over the student teacher than university supervisors. Somewhat ironic since they also document how CTs aren’t involved in much decision-making. Using triad theory, authors analyzed interviews with CTs (N=23) to flesh out their descriptions of interactions with both STs and USs. Authors identified that two types of triads emerge during student teaching: a functional triad and an institutional triad. In the former, the CT holds most power and the US has power in the latter. The authors suggest that models of supervision emphasizing increased collaboration among triad members be created.</td>
<td>Role of Clinical Educator in each Medical &amp; Teacher Education</td>
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<td>Borko &amp; Mayfield (1995)</td>
<td>Authors used data from the longitudinal study, Learning to Teach Mathematics, to study the influence university supervisors and cooperating teachers have on student teachers’ learning to teach process.” Participants included each four student and cooperating teachers. Data included observations of conferences between the ST and CT and interviews with each STs and CTs. Findings did not reveal significant changes in STs’ beliefs and developing practice. Partly because CTs didn’t engage STs in regular, extensive conversations about complexities of teaching and learning, they failed to realize the full potential they could have on STs’ development.</td>
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<td>Bullough &amp; Draper (2004)</td>
<td>The study focused on one student teaching triad. Cooperating teachers were referred to as “mentors.” They met with researchers throughout the study to discuss research about mentoring, kept logs of interactions with interns, recorded conversations they engaged in with other mentors, and completed an interview.</td>
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<td>Valencia et al. (2009)</td>
<td>Authors studied nine student teachers (five from secondary English). They interviewed and observed each student and cooperating teachers, as well as university supervisors. Findings revealed that all triad members struggled with identity in competing contexts, there were few substantive discussions about subject specific teaching and learning issues, and scant feedback was given to student teachers.</td>
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<td><strong>Contributions to Understanding of Meaning Making in Medical Education</strong></td>
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<td>Yardley, Brosnan, &amp; Richardson (2013)</td>
<td>Authors used interviews to gain clarity on medical students’ (N=23) knowledge construction and meaning making within the context of Authentic Early Experiences. Supervisors (N=20) and medical school faculty (13) were also interviewed. Medical students (N=14) also participated in discussion groups, as did new participants (N=12). Each narrative and interpretative phenomenological analysis were used to “access knowledge and meaning constructions” (p. 112). Authors found that there are “unintended consequences” to AEE, which are related to students’ meaning making during the experiences. It was also found that meanings student make during AEE (i.e. metis), influence the formation of their professional identity.</td>
<td>Meaning Making</td>
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<td>Irby (1994)</td>
<td>Though the case study focused on knowledge bases clinical teachers (N=6) draw on in their work with novices, meaning making did arise. Irby calls on Hunter’s work, which identifies the “patient as text” (p. 340). Clinical teachers must guide novices through meaning making of the patient’s illness and help novices connect meanings made to other cases and to larger, relevant bodies of knowledge. Through these meaning making activities, both clinical teacher and novice practitioner build scripts that can be called on in future moments of practice.</td>
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In her ethnographic study, funded by a grant from the National Science Foundation, the author spent two years observing features of internal medicine’s and surgery’s clinical education. Focusing on the “interaction between physicians teaching and learning to take care of patients…”, she paid particular attention to the use of “‘literary’ phenomena” (p. xiv). She determined that the practice of medicine is art, not science, and narrative structures permeate occasions of teaching, learning, and the enactment of professional medical practice.

Authors launched a pilot study in 2005 (N=9); the participant pool grew each year and there were 60 medical students and 58 mentors in 2008. Students were engaged in a Practical Immersion Experience; by adding the Narrative Strand to this clinical experience, authors aimed to have students use writing as a way to “discover and examine the ways they made meaning of their new experiences in the field” (p. 250). Students grappled with, among others, professional identity and professional values. Mentors did not grade writing. The experience proved helpful for most students and mentors and seemed to contribute to reflective, mindful practice.

Rosenblatt’s text, *Literature as Exploration*, was originally published in 1938. The text provides a comprehensive explanation of Rosenblatt’s transactional theory. Her work is a call for educators to establish classroom communities where students’ informed, personal responses to literature are heard, acknowledged, and respected. Reading is an active and creative process for a particular person at particular moments in time.

Using a narrative inquiry methodology, the author studied two novice teachers’ experiences with meaning making in the secondary English language arts classroom. Building on Rosenblatt’s work, she developed the Classroom Literacy theoretical framework. Edge found that participants, or “readers” of the “classroom as text,” called on prior experiences to make meaning of present classroom experiences. Novice teachers, the classroom space, and the secondary ELA students transact with one another.

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<th><strong>Table A.1 (Continued)</strong></th>
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<td><strong>Contributions to Understanding of Meaning Making in Teacher Education</strong></td>
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<td>Authors launched a pilot study in 2005 (N=9); the participant pool grew each year and there were 60 medical students and 58 mentors in 2008. Students were engaged in a Practical Immersion Experience; by adding the Narrative Strand to this clinical experience, authors aimed to have students use writing as a way to “discover and examine the ways they made meaning of their new experiences in the field” (p. 250). Students grappled with, among others, professional identity and professional values. Mentors did not grade writing. The experience proved helpful for most students and mentors and seemed to contribute to reflective, mindful practice.</td>
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Appendix B: Interview Protocol

Three, ninety-minute interviews will be conducted with each of the two participants.

As the researcher, I aim for what is shared during each interview to relate back to the study’s research question:

*How do professional educators (cooperating teachers and attending physicians) make sense of their role in helping novice practitioners make meaning from authentic clinical practice?*

The first interview will give participants the opportunity to share details about their life history. According to Seidman (2013), the first interview helps “put participants’ experience in context by asking [them] to tell as much as possible about [themselves] in light of the topic up to the present time” (p. 21). During the first interview, participants can also share important details about where they enact their clinical educator role. Understanding participants’ professional practice context is key to understanding what they will share about their professional practice in subsequent interviews.

The second interview will allow participants to focus on detailing their present lived experiences as they relate to the research question. As participants share stories related to the research question, I will work to ensure that they don’t drift into providing their opinions about the details of the experiences. Seidman (2013) notes the importance of ensuring that participants “concentrate on the concrete details of [their] present lived experience in the topic area of the study” (p. 21).

The third and final interview will serve as a space during which participants “reflect on the meaning of their experience” (Seidman, 2013, p. 22). This exchange should allow meaning about participants’ present lived experiences to flow from the groundwork created during the prior interviews. In this way, participants can come to understand how the context and the reflected on, lived experiences within that context might inform today’s lived experiences.

**Areas for exploration during the series of interviews:**

1. What are the key influences of participants’ own training that influence their sense making?

2. What are the similarities and differences in how participants make sense of their role and the influence they believe they have on novice practitioners?

3. What do participants identify as the barriers and facilitators to their work with novice professionals?

4. What can we learn about professional education by understanding each professional’s story?
Interview One Guiding Questions

• Can you describe your work history?
  ○ Are there any points in which you felt you had, at least partly, an educator role? Can you elaborate on that?

• Can you describe how you came to medical education/teacher education? As a student? As an educator?

• Can you describe any poignant clinical education experiences from when you were a medical student/preservice teacher? Resident/Intern?

• Thinking back on your GME/student teaching experiences, do you recall attendings/cooperating teachers helping you make meaning of your clinical practice experiences? What can you share about those attendings/CTs (i.e. in their role of clinical educator)? About those meaning making occasions?
  ○ Does what you thought of attendings’/cooperating teachers’ educative actions then differ from what you think about those actions now? Can you elaborate on that?

• When you first became an attending/cooperating teacher, did you draw on what you experienced as a resident intern interacting with attendings/CTs (i.e. for the purpose of professional development) to inform your clinical educator role?

Interview Two Guiding Questions

• How would you describe your role of clinical educator?
  ○ Do you think this description would hold true across GME contexts/teacher education contexts?

• What do you believe to be the primary functions of the clinical educator role?
  ○ Do these align with what you feel you are able to do at your particular professional practice context? If so, what factors support you in that? What are some barriers?

• What does it look and sound like to help a novice make meaning from clinical practice experiences?
  ○ Do you believe these interactions have implications for how novices go on to think about their professional practice? For the choices they will make as independent professionals? Can you elaborate on your thoughts?

• In your role of clinical educator, what does it mean to help a novice practitioner form into a professional?

Interview Three Guiding Questions

• Considering what you have shared about your professional and medical/teacher education experiences before you became a clinical educator, and what you have shared about your
experiences being a clinical educator, how have you come to understand the clinical educator role? What has it come to mean to you to be a clinical educator who is charged with helping novice practitioners make meaning from clinical practice experiences?
Informed Consent to Participate in Research
Information to Consider Before Taking Part in this Research Study

IRB Study # Pro00020485

You are being asked to take part in a research study. Research studies include only people who choose to take part. This document is called an informed consent form. Please read this information carefully and take your time making your decision. Ask the researcher or study staff to discuss this consent form with you, please ask him/her to explain any words or information you do not clearly understand.

We are asking you to take part in a research study called:
Perspective from two professions: Two professionals making meaning of the clinical educator role

The person who is in charge of this research study is Tara Payor. This person is called the Principal Investigator. However, other research staff may be involved and can act on behalf of the person in charge. Dr. Diane Yendol-Hoppey is guiding Tara in this research; as such, she is Co-investigator.

The research will be conducted at a public coffee shop close to each participant’s place of employment.

Purpose of the study
The purpose of this study is to:
• The purpose of this study is to describe how professional educators (i.e. cooperating teachers and attending physicians) make sense of their role in helping novice practitioners make meaning from authentic clinical practice. You are being asked to participate in this study because of your role as either an attending physician or cooperating teacher who works closely with novice practitioners (i.e. either resident physicians or student teachers). Both fields are marked by a lack of understanding about the clinical educator role. Setting the stories of a clinical educator from each profession side by side can help speak to the interest both professions have in learning from other professional fields to improve clinical education.
• Tara Payor, the Principal Investigator for the study, is a doctoral candidate in the College of Education at the University of South Florida. She is a part of the Department of Teaching and Learning. Her concentration area is secondary English education. Tara is carrying out this study for her dissertation.

**Study Procedures**

If you take part in this study, you will be asked to:

Take part in a series of interviews:

• *There will be three interviews.*
• *Each interview will last a total of 90 minutes. There will be a period of three to seven days between each of the interviews.*
• *We will meet at a coffee shop close to your place of employment so that your travel time is minimal.*
• *Interviews will take a semi-structured format. Meaning, the PI will have guiding questions prepared ahead of time.*
• *Each interview will be audio-recorded. Recordings will be sent to a transcription service, and their confidentiality agreement will be available for your review should you wish to read it. Beyond the transcription service, only the P.I. will have access to the audio recordings.*
• *All data will be kept in a locked filing cabinet and the P.I.’s password protected laptop computer. Audio recordings will also be stored on the P.I.’s password protected laptop computer. All data will be retained for a minimum of five years after the final report has been submitted to the USF IRB. Following the five years, a shredder will be used to destroy paper documents; audio files will be completely deleted from the P.I.’s digital recorder and laptop computer.*

**Total Number of Participants**

Two individuals will take part in this study. The participants will not be employed at the same place and will not meet with the P.I. at the same time.

**Alternatives**

You do not have to participate in this research study.
Benefits

Through participation in the study participants may contribute to the present gap in each the teacher and medical education literature about the clinical educator’s role and the part s/he plays in helping novices understand their experiences in the clinical practice context. Additionally, participating in the study might give participants opportunities to reflect on their work as clinical educators in ways they had not previously done. As a result, participants might make positive changes to their professional practice as clinical educators.

Risks or Discomfort

This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study.

Privacy and Confidentiality

Your study records will be kept private and confidential. Certain people may need to see your study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

- The research team, including the Principal Investigator and study coordinators.
- Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety.
- The Department of Health and Human Services can review.
- The USF Institutional Review Board (IRB) and its related staff who have oversight responsibilities for this study, staff in the USF Office of Research and Innovation, USF Division of Research Integrity and Compliance, and other USF offices who oversee this research.

We may publish what we learn from this study. If we do, we will not include your name. We will not publish anything that would let people know who you are.

Voluntary Participation / Withdrawal

You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study.

You can get the answers to your questions, concerns, or complaints

If you experience an unanticipated problem related to the research call Tara Payor (Principal Investigator) at (813) 732-5360.

If you have questions about your rights as a participant in this study, general questions, or have complaints, concerns or issues you want to discuss with someone outside the research, call the
USF IRB at (813) 974-5638.

Consent to Take Part in this Research Study

It is up to you to decide whether you want to take part in this study. If you want to take part, please sign the form, if the following statements are true.

I freely give my consent to take part in this study. I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form to take with me.

_____________________________________________  ________________
Signature of Person Taking Part in Study                     Date

Printed Name of Person Taking Part in Study

Statement of Person Obtaining Informed Consent

I have carefully explained to the person taking part in the study what he or she can expect from their participation. I hereby certify that when this person signs this form, to the best of my knowledge, he/she understands:

• What the study is about;
• What procedures will be used;
• What the potential benefits might be; and
• What the known risks might be.

I can confirm that this research subject speaks the language that was used to explain this research and is receiving an informed consent form in the appropriate language. Additionally, this subject reads well enough to understand this document or, if not, this person is able to hear and understand when the form is read to him or her. This subject does not have a medical/psychological problem that would compromise comprehension and therefore makes it hard to understand what is being explained and can, therefore, give legally effective informed consent. This subject is not under any type of anesthesia or analgesic that may cloud their judgment or make it hard to understand what is being explained and, therefore, can be considered competent to give informed consent.

_____________________________________________  ________________
Signature of Person Obtaining Informed Consent                     Date

Printed Name of Person Obtaining Informed Consent
Appendix D: Internal Review Board Approval

Appendix D: Internal Review Board Approval

January 22, 2015
Tara Payor
Teaching and Learning
Tampa, FL 33626

RE: Expedited Approval for Initial Review
IRB#: Pro00020485
Title: Perspective from two professions: Two professionals making meaning of the clinical educator role

Study Approval Period: 1/22/2015 to 1/22/2016

Dear Ms. Payor:

On 1/22/2015, the Institutional Review Board (IRB) reviewed and APPROVED the above application and all documents outlined below.

Approved Item(s):
Protocol Document(s):
Study Protocol

Consent/Assent Document(s)*:
Informed Consent to Participate in Research for Dissertation.docx.pdf

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent document(s) are only valid during the approval period indicated at the top of the form(s).

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review category:
(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history,
focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

John Schinka, Ph.D.

John Schinka, Ph.D., Chairperson
USF Institutional Review Board
## Appendix E: Data Analysis Organization Table Excerpt

### Table E.1: Data Analysis Organization; an Excerpt

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subtheme</th>
<th>AT</th>
<th>CTT</th>
<th>Relationship to professional formation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional education experiences influencing clinical educator role</td>
<td>Positive mentorship experience</td>
<td>I 10 I could just compare working for, ‘Ben’, was the name of the anthropologist I worked for. I have a very close relationship with him. I worked for four years, I lived at his house my last year of undergrad, we had a very close relationship. Working for him, and going to work every day, I didn't know what kind of conversation I was going to have, it was amazing. Exciting, I had no idea what was going to happen that day in terms of conversation or where I was going to go….</td>
<td>I 13 I was lucky to work within a great team of very experienced teachers as a new teacher. They really taught me how to teach. I got to watch them teach…. I remember thinking that I got to stand on some great people's shoulders and really did. That was very, very fortunate….. I was able to intern here under Carol, who was also a giant, that I loved standing on her shoulders. I was intimidated if anything from her my first year. She was a very powerful model, but I got to work as an intern in her classroom.</td>
<td><strong>Ongoing self-reflective process; habits of thought, feeling, &amp; acting</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>I 21 so she was already a national board teacher.</td>
<td>I 21 Now, I realized afterwards, after speaking with her, how powerful that was for me as my first real learning experience.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>I 21** To this day, I still hear her in my head but it took me a while at that time for my age. She'd always ask me, &quot;Why, why, why.&quot; She's always asking, &quot;Why.&quot; I got to the point where I did not like the word &quot;why&quot; because I felt like I just explained it to you and then she'd come around and she asked me the same question about why, why, why….She learned what I was thinking by asking that constant question. That's how she learned about what I was processing….I had to give her a response, I felt I had to, I was her preservice or intern.</td>
<td>I vowed I would never ask that question to my intern. I never know and then I'll catch myself asking why, but I didn't do it to the extent that she did it but she had a great way of doing it. I mean I was determined to prepare myself and I was thinking about why I did something, why I did it that way, or why I approached the lesson this way, or why I did it that way….That was her way of getting me to start understanding what I was doing. &quot;Why that approach Tori? Why did you do it that way? Why didn't you do it this way?&quot;</td>
<td></td>
</tr>
</tbody>
</table>
Appendix F: Data Analysis Transcript Excerpt

**BACKGROUND EXPERIENCES**

*Positive experience/mentor relationship during early training*

**AT I 10** I worked in some type of jobs since I was 15-years-old.

In high school I worked part time, and always worked in something. I could just compare working for Ben was the name of the anthropologist I worked for. I have a very close relationship with him.

I worked for four years, I lived at his house my last year of undergrad, we had a very close relationship. Working for him, and going to work every day, I didn't know what kind of conversation I was going to have, it was amazing.

Exciting, I had no idea what was going to happen that day in terms of conversation or where I was going to go, versus going to work at the telemarketing place.

**CTT I 3** I liked the classes. I really did. It was all theory. However, more experience with in the classroom with working with some great teachers. I was lucky to work within a great team of very experienced teachers as a new teacher. They really taught me how to teach. I got to watch them teach.

… I remember thinking that I got to stand on some great people's shoulders and really did. That was very, very fortunate.

… I was able to intern here under Carol who was also a giant that I love standing on her shoulders. I was intimidated if anything from her my first year. She was very powerful model, but I got to work as an intern in her classroom.

**CTT I 21** Anyway, long story short, ultimately my final internship I ended up in Carol’s classroom at X Middle with a fantastic. She's a very powerful, loud person.

At that time I was very meek and mild but I felt confident because I was married and I had gone to a couple universities. I felt like I had more worldly experience than some of the interns that I had worked with. I was actually one of the older ones at 24 in the class.

... She did national boards, so she was already a national board teacher. It frightened me at first. ...

**CTT I 21** The first couple weeks I was a student in her class, more or less. I had to work in the writing group and write with that. But she'd pull me out to work with her.

She always said to me, "You had to do the work too. You can't just give the kids the work. You have to experience it as well. …

I was a little annoyed at that. I'm thinking, "No, I'm a college graduate here. I don't want to have to write. I don't want to do that." Now, I realized afterwards, after speaking with her, how powerful that was for me as my first real learning experience.
To this day, I still hear her in my head but it took me a while at that time for my age. She'd always ask me, "Why, why, why." She's always asking, "Why." I got to the point where I did not like the word "why" because I felt like I just explained it to you and then she'd come around and she asked me the same question about why, why, why.

…She learned what I was thinking by asking that constant question. That's how she learned about what I was processing when she constantly ask a question. I had to give her a response, I felt I had to. I was her preservice or intern. She knew that and she used that, but she asked me why.

I vowed I would never ask that question to my intern. I never know and then I'll catch myself asking why, but I didn't do it to the extent that she did it but she had a great way of doing it. I mean I was determined to prepare myself and I was thinking about why I did something, why I did it that way, or why I approached the lesson this way, or why I did it that way. ALIGNS WITH PROFESSIONAL FORMATION: REFLECTIVE HABIT OF MIND; “ONGOING SELF REFLECTIVE PROCESS”

I was starting on that process of, "Man, I hated that word why." That was her way of getting me to start understanding what I was doing. "Why that approach Tori? Why did you do it that way? Why didn't you do it this way?"

We did that part of that. I was lucky to be in her classroom and I would go back today and certainly I could just absorb her teaching and be in that classroom. But I'll kind of do it in a different way because I felt, for me in my personality, it was abrasive. I always felt offensive.

As a new intern, I felt always like, "Oh, my gosh! I'm not going to do it right." I was one of those and wanted to always do it right. Now, in that role, I say, "How could we do it better? How do you think this would've been? How do you think it would've gone if we did this?" PF: INTENTIONALITY IN ACHIEVING EXCELLENCE

I'm going to do it in that direction of how instead of just that simple why question. Even though I think that why is powerful, absolutely and I've used it before, but I kind of say how to kind of give them that opportunity to explain it in the how method instead of just why.

Carol. She was so involved with the writing project and it was so overwhelming, but there's a lot of things I do in my classroom that I probably use and I probably don't even realize I use now from her. But also getting to experience other wonderful teachers’ classrooms that I've had the opportunity to be in as well.
Appendix G: Poetic Writing as a Data Analysis Tool

The following are known as “I” poems. Gilligan, Spencer, Weinberg, and Bertsch (2003) created a “listening guide” for the analysis of interview transcripts. The authors note that the listening guide helps “open a way to discovery when discovery hinges on coming to know the inner world of another person” (p. 157). The aforementioned is well aligned with the present study, as the in-depth phenomenological interviews were interested in Tom and Tori’s worlds, not mine. The “listening” that the authors refer to is truly a careful series of readings of the interview data. Throughout the readings, the text is marked up and the researcher is intently focused on “listening” to the speaker’s voice—“to hear how this person speaks about him or herself” (p. 162). By using this as an additional approach to data analysis, I was able to capture Tom and Tori’s alignment with the professional formation conceptual framework and parsimoniously present what were extensive passages of interview data. Being presented in the first person voice helps ensure that readers are intently focused on the ways Tom and Tori make sense of their clinical educator role and not how I, the researcher, made meaning of their descriptions.
I Poems

Tom
I think about it
I am…do it better than me
I have…thousands and thousands of
patients
I know
I can step in
I had been around people
I want them to understand
I know what I’m doing
I want them to recognize
what I’m doing has purpose and
meaning
I’m going to do that today
I try to teach the residents
I think that’s the responsibility we have
I think it would take some time
I could leverage my ideas
I think

Tori
I decided
I just wish
I could do more
I’m open
I’m teaching
I’ll talk to you
I’m very into…how to use it for the
betterment, for the learning, of the kids
I had to constantly ask that question
I was going through the process
I did
am I impacting students positively or
negatively
I didn’t think you could
I realized
I impact them as a teacher
I was teaching
I remember
I’d like to go back
I’m sorry
I’ll take you all back
I would stand
I’m torn
I know
I tell the kids
I tell them
I can remember
I purposely try
I don’t do it well
I’ll tell them that
I didn’t do that well today
I’m not crying
I’m not upset
I’m reflecting about it
I’m talking about it
I guide that
I could’ve done it better
I try to model that
Another poetic form I used is the “Change” poem. Originally, I included the “Change” poems in the closing of the across-participant-description. After several discussions with committee members, and my sense that removing the poems from that section might help keep readers’ attention focused on a more streamlined presentation of findings, I decided to place the poems in an appendix. As the researcher and writer, I did not want to fully omit the poems from the document because they were a part of my meaning making process.

The “Change” poems include some of the participants’ own words. Beyond presenting research findings the poems show that, through the analysis process, I developed the understanding of and fluency with interview transcripts necessary to present salient findings in concise, poetic form. The “Change” poetic form is a take on the “Toast to Change” found in the Freedom Writers Diary (Gruwell, 1999). I became familiar with the poem during my time as a high school English teacher. I also utilized the poem in my work with preservice teachers in the college of education. Given Tom and Tori’s commitment to change (e.g. ongoing engagement in professional development so that conditions for the population(s) they serve have a stronger chance of being improved), the format felt appropriate as an additional way to present findings.

**Tom: [Commitment to] Change**

I was an anthropologist in the making.
I remember the Bolivian revolution.
I heard the Fulbright falling out of my hands--no tools to salvage that dream.
I saw the fellow medics working--helping, researching, and coming into their physician being.
I worried about changing course. 26. It's not too late to leave academe.
I thought I'd be the next Boaz.
But, I had to change.

I am a part of this EM tribe.
I think through our unique mindset, which is now a part of ME.
I need to expand the scope of my responsibilities so that, partly through ME, more of thEM are reached.
I try to learn from those who've come before ME.
I feel optimistic about the program development I see.
I forgive those who did not feel it was in them to help ME.
Now I can change.

I will be everything I believe a physician to be. Community leader, educator, and researcher.
I choose to share all parts of myself with those looking to learn from ME.
I hope I can help thEM identify the kinds of physicians they aspire to be.
I predict I will continue pushing all parts of me forward, blurring boundaries intentionally.
I know I will be a contributor to our field.
I will change

Tori: [Commitment to] Change

I was determined not to teach.
I remember the children, in crisis, in need.
I heard their clinical, too dry, way of being.
I saw how to marry my interests to help children with special needs.
I worried I wouldn’t get it all right.
I thought I had learned to teach.
But, I wanted to change.

I am a teacher, on the team.
I think things always have some good.
I need to continue positively impacting all of those kids.
I try to put myself out there so that I can continue refining the ways I teach.
I feel optimistic.
I forgive those who choose not to join forces with me.
Now I can change.

I will be the best professional educator I can be.
I choose to focus on the positive and dismiss the deficit view.
I dream of learning from those I once taught.
I hope we are a community of learners—in a constant back and forth.
I predict I will remain firmly grounded on my humble teaching path.
I know I will reflect on and revise my practice so that I reinforce our learning network.
I will change
Appendix H: Researcher Reflections

Seidman (2013) encourages researchers to engage in reflection as the research process comes to a close. He encourages researchers to consider “what…the work [has] come to mean” (p. 131).

The work has come to mean opportunity to teach and collaborate. Through the research process, I got to know two clinical educators who are committed to improving as professionals and to improving teaching and learning experiences for the novices they work with. Both expressed interest in collaborating with teacher educators so that they are better prepared to enact the clinical educator role and clinical education experiences for novices are strengthened through things like increased conceptual and structural coherence. This work has come to mean that, through our collaborative efforts, I have a responsibility to help these two clinical educators achieve their goal of improving clinical education experiences.

This work has come to mean that I have a responsibility to contribute to building the professional field. Given the nature of this work, I believe I can make these contributions in three contexts: teacher education (my home base), the 6–12 school context (my place of origin), and medical education (a border now open to me). I believe I am positioned to begin doing this work at the local level. Through my intentional efforts to build relationships and broaden my network of clinical educators, in both professions, I believe this work can lead to work at the national level. As such, there exists potential to positively impact a greater number of clinical educators, novice practitioners, 6–12 students, and patients.
The way my personal and professional lives intertwined has been noted elsewhere within this document. As I moved through the series of interviews, this intertwining was further evident to me. Because of my husband’s previous experience with Tom and Tom’s residency program, I had some knowledge about particular features of the program and people within it. Though I did not necessarily have this knowledge as a result of firsthand experiences, there were things that Tom referenced (e.g. the mentorship program) and people he made mention of (e.g. the residency program director) that I knew about. That knowing appeared to help individual interviews progress with a certain ease—from my particular standpoint as the interviewer. I say that because, for example, as Tom spoke about other clinical educators within the program I found it helpful to know certain details about their roles and responsibilities; this is knowledge I had as a result of my quasi-insider experiences with the program. It’s important to note that this knowledge is neither personal in nature nor rooted in gossip about particular educators. Rather, due to the way residency tends to subsume so many aspects of one’s life, and that my husband spent three years with Tom’s program, there were processes and people I developed some knowledge about.

I feel some of this knowledge was helpful in keeping individual interviews moving along because there were certain points when I did not need to stop and ask for clarification. For example, as Tom detailed the residency’s mentorship program I had enough familiarity with it that I was able to focus on probing questions specific to his role rather than on a multitude of questions about the origins and structure of the program. There were points during the series of interviews when Tom made specific reference to my husband as he tried to describe a specific quality (e.g. lifelong learning), for example.
I don’t believe that this was damaging to the study in any way, nor do I believe it necessarily strengthened the study in any particular ways. As I stated previously, it might have helped make parts of the individual interview progress more seamlessly because I didn’t feel the need to seek clarification about certain things due to the knowledge I had regarding what Tom was referencing.

To underscore, I don’t believe the aforementioned made me approach data analysis any differently. I also don’t believe that, had another researcher without the same connections to the program as I have carried out the study, s/he would have emerged with markedly different interview data. I believe the essence of what was shared, the substance, would have remained the same.

When speaking with Tori, there were also a couple of points when I saw signs of the intersection of my personal and professional lives. For example, as Tori shared details of her experiences working with physicians in the mental health field, there were things that resonated with me because of my lived experiences with physicians—my husband in particular—which differed from the patient/doctor relationship kind of lived experience. As she articulated things she noticed about physicians’ personalities, for example, they rang true with me because of my close relationships with a number of physicians. Again, this is not something I believe changed the course of individual interviews or the data analysis process. I have the mental discipline and the integrity to the research process to separate personal feelings from what I need to do as a researcher.

I can’t write about what this research experience was like without acknowledging that I gave birth to our son as I carried out the study. Being full term in my pregnancy as I interviewed Tom, and a mother to a newborn as I interviewed Tori, was at times
energizing and at others exhausting. I felt motivated to push forward with the research process, as I knew caring for another human being would add another layer of complexity to doing my research work. Speaking to the concept of boundary blurring, Tom and I joked that he would be able to deliver the baby if I went into labor during one of our interviews. Tori and I spent a few moments before each of the interviews talking about the role of mother and its impact and influence on the professional role. At times, I felt broken down—particularly during our son’s first few months of life. I remember making coffee at 3 A.M., as I rationalized that I wasn’t sleeping anyway. While the house slept, the newest member rather intermittently, I set to work on interview protocols—using my cell phone as a light source. During that time, too, our son underwent emergent surgery to remove a congenital cataract from his right eye. I believe that the dissertation/research process was, in some ways, a saving grace. It gave me something else to focus on: cognitively and behaviorally.

Waking up at 4 A.M. became a habit so that I could (hopefully) get a couple of hours of work in before the children demanded my full attention. The sleep deprivation undoubtedly began to impact my sense of self-efficacy as a researcher. I doubted the quality of my work (more than usual) and had to be intentional in my own efforts to (a) keep my morale from plummeting and (b) keep the momentum moving forward. Working through the fatigue, or maybe with it, I again found myself thinking about aspects of my personal and professional crossroads. As my husband spent six years in graduate medical education, after four years of medical school, there seemed to be no questioning (e.g. by family and friends) of what he was doing. He was, for all intents and purposes, already a doctor. And, after residency, would only garner more respect. As I
progressed through the research process, I felt people had little idea what I was doing and
didn’t give the work—the education related work—the same sort of respect they gave my
husband’s. While it was, apparently, completely acceptable for his post-
baccalaureate/medical education to take a total of ten years, I sensed people thought I was
taking too long just carrying out the present study. I felt people did not have any real
understanding of the research process. I acknowledge my perceptions may have been
entirely off base and emanated from my acute awareness of where each medicine and
teaching stand, as far as respected professions, with the public at large.
Appendix I: Tables Showing Alignment Between “I Am” Poems and Data

The table below includes lines from the “I Am” poem that opened chapter four. When looked at individually, along with illustrative transcript excerpts, it is clear that lines from the poem respond to the research question. Whether lines are looked at individually or the poem is taken as a whole, the poem is an artistic representation of the ways Tom makes sense of his clinical educator role. In the middle column of the table, I explain the connection between the line from the poem and the ways Tom makes sense of his clinical educator role.
Table I.1: Evidence for Tom’s “I Am” Poem

<table>
<thead>
<tr>
<th>Line from Tom’s “I Am” poem</th>
<th>How line speaks to the ways Tom makes sense of his clinical educator role</th>
<th>Illustrative interview transcript excerpt</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am a multifaceted thinker.</td>
<td>When Tom thinks about his clinical educator role, he takes the varied dimensions of the professional practitioner’s role into account. Then, he is sure that his clinical education work is attentive to what he considers important dimensions of the physician role.</td>
<td>My mission is to show what it is to be a doctor, the whole package of doctor. To recognize that is going to be behavior-based, and also knowledge-based…. That’s exactly what my mission is. It’s to show what this whole package looks like, what the whole thing looks like. It’s not just one piece here or there. It’s teacher, educator, community leader, the whole thing.</td>
</tr>
<tr>
<td>I wonder if I can instill curiosity.</td>
<td>Tom views it as his responsibility to help novices use professional practice as a catalyst for inquiry. As a physician, he understands the unpredictability of professional practice. As a clinical educator, he views it as his responsibility to instill curiosity in novices because professionals must constantly ask thoughtful questions if practice is to be helpful to patients and constantly developing.</td>
<td>So much of it’s not algorithmic driven. We have algorithms, but we fall off of them all the time, constantly. I can teach algorithm. That’s one form of teaching. It’s part of our responsibility. That’s what grammar is for. That’s what testing’s for. We’ll make sure you know all these algorithms. What do you do when you fall off the algorithm? How do you approach the patient? That’s what I mean about the curiosity part, the thinking part, the asking questions part, that’s where you get those things. That’s part of my job too.</td>
</tr>
<tr>
<td>I hear their questions—things I hadn’t thought about since my neophyte days.</td>
<td>Tom understands that he must play an active role in novices’ clinical practice experiences because they do not have the depth of knowledge to make meaning of experiences on their own. In his clinical educator role, he is intentional in addressing what has become tacit knowledge for him.</td>
<td>Every July, chest pain is brand new again…. I literally hear that in my mind every time a third year medical student presents to me I think, “This is all brand new to this person.” I can literally put myself right back in 2004. I say, “OK, see yourself in 2004, this is all brand new, this whole thing is brand new.” That is to remind yourself over and over again….</td>
</tr>
<tr>
<td>I see them growing in their capacity to study problems of practice.</td>
<td>Tom sees it as his responsibility to help give novices authentic experiences studying problems of practice. As novices show curiosity and develop knowledge and skills, he helps make it possible for them to collaboratively study problems of practice with people other than him.</td>
<td>Behind you there, I had a resident here a couple of days ago. I had one of the big cardiologists in here a couple of days ago. My resident was really interested in a question of a special kind of heartbeat called atrial fibrillation and whether we were doing it the right way. I said, “Well, let’s get a group of people together and we’ll talk about it, and we’ll see what we think, and we’ll see if we can come up with a study for it.”</td>
</tr>
<tr>
<td>Line from Tom’s “I Am” poem</td>
<td>How line speaks to the ways Tom makes sense of his clinical educator role</td>
<td>Illustrative interview transcript excerpt</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>I want them to own the tools.</td>
<td>Tom does not understand the clinical educator role to mean that he always does the professional practice and novices observe. In order for novices to own the conceptual and practical tools, he must teach through lecture, discussion, and modeling, but he must also step back and let novices make mistakes.</td>
<td>My role, the ability I have of seeing thousands and thousands of patients, is I know when your failure is going to be a danger and I can step in. But, until your failure is a danger, there’s no reason I need to step in….</td>
</tr>
<tr>
<td>I pretend to be more confident. I feel hesitant to show all parts of me.</td>
<td>Though Tom believes it is important for him to show novices the varied dimensions of the physician role, he has not always been fully confident doing so. As he grows in his clinical educator role, he grows increasingly confident sharing all parts of himself. In his role, Tom remains humble and aware of his shortcomings.</td>
<td>Part of [it]…is being confident in all the aspects of who I am as a physician, to model them and show them, and not put them to the side and say, “That’s just something I do.” I think I felt that way for a while. The politics is just something that I do, but it’s not something all physicians need to do.</td>
</tr>
<tr>
<td>I touch lives—patients, practitioners, and novice physicians learning to be.</td>
<td>Tom understands that his clinical educator role makes it possible for him to continue positively impacting patients—either through direct care or through the care provided by the residents he teaches. Also, his clinical educator role is marked by collaboration with other faculty members and physicians from other specialties.</td>
<td>(A) When I come out of a room, if I hear a presentation where a resident sounds cold, or dry, they say, “Well, you just need that CT scan of your belly, otherwise you might have a blood clot. You may want to get radiation.” Let’s sit down, think about this for a second. Let’s just, That’s your wife in there. That’s your kid in there. In that belly, that’s your baby, now let’s just re-have that conversation. (B) We now have a monthly just-core-faculty-member meeting to talk about education-related things…. Some of those things that you want to talk about as a core educator who’s trying to get better at this and whose mission is to do this are things that are very specific to education…. I think that’s been great because it keeps us talking about what we’re doing and where we want to go as a program and those types of discussions.</td>
</tr>
</tbody>
</table>
Table I.1 (Continued)

<table>
<thead>
<tr>
<th>Line from Tom’s “I Am” poem</th>
<th>How line speaks to the ways Tom makes sense of his clinical educator role</th>
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</tr>
</thead>
<tbody>
<tr>
<td>I worry we aren’t doing enough.</td>
<td>For Tom, the clinical educator role calls for continuous professional development. Though he is intentional in trying to improve his clinical educator practice and works to make changes at the local level, he understands that the field as a whole must improve its efforts to teach the teachers.</td>
<td>GME’s probably behind…on how they think about teaching teachers, and always has been…. The other associate medical director is doing one right now, over at [the simulation center,] that has how to be a program director, how to be a mentor, all those kinds of things that you actually need. GME probably should offer to people who want to be teachers. It’s those exact tool sets you need.</td>
</tr>
<tr>
<td>I lament lost opportunities.</td>
<td>Tom is mindful of the fact that he has limited time to work with novices. When he considers the big picture (i.e. the entire three years of the residency), he understands that novices do not spend all of that time learning from experienced ED physician-educators.</td>
<td>You do that three years, so it’s hard to remember that if you actually drill down on it for a second, you have 36 months, 18 of those in the ED, times 12 or 20, whatever shifts it is. Each one of those is one pluck off the learning tree. That’s it. That opportunity’s gone to have an experienced provider sitting right in front of you with knowledge. That experience is gone each time.</td>
</tr>
<tr>
<td>I understand we don’t have it all figured out.</td>
<td>Regularly thinking about varied aspects of clinical education is a characteristic feature of Tom’s role. Through his reflective practice, he is able to identify areas for improvement.</td>
<td>I think any resident should be able to come to any one of the 10 core faculty members that are assigned as a mentor and get a great mentorship experience or a great education experience. But, we have to have some tools there. I think tools is…something we can improve on…. Teaching the teacher kind of thing.</td>
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<tr>
<td>I say keep questioning, developing, and doing.</td>
<td>With more autonomy, Tom expects that novices will continue doing the things he has helped instill in them, such as demonstrating curiosity.</td>
<td>They’re supposed to be starting to learn to run the department by the third-year…. Running the department means collaborative approaches to patient care, leadership, starting to think about their lives as attendings in terms of how they would change policy and process.</td>
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<tr>
<td>I dream of a capable, confident, and unified tribe.</td>
<td>For Tom, autonomy does not come at the expense of collaborative practice. For him, it is important that the professional role be developed alongside other supportive emergency medicine physicians who share similar ways of thinking, doing, and being.</td>
<td>It’s useful to pull all the residents together for five hours a week. There’s a sense of self, “This is us, this is our tribe. This is who we are. This is how we act. This is how we behave. This is how we see the world.” ….why not come back to your home, people who like you, people who support you, and people who have your best interests at heart and are trying to teach you….</td>
</tr>
<tr>
<td>Line from Tom’s “I Am” poem</td>
<td>How line speaks to the ways Tom makes sense of his clinical educator role</td>
<td>Illustrative interview transcript excerpt</td>
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<td>I try to share all of who I am.</td>
<td>Tom understands his role to be multifaceted in nature. He is intentional in working to share all facets with novices, as doing so contributes to the authenticity of the clinical practice experience.</td>
<td>It’s teaching them what my version of being a doctor is, versus another person’s version of being a doctor…. My version of being a doctor is this community leader, academic person who’s also a very good healer of patients. That, to me, is what a doctor is….</td>
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<tr>
<td>I hope to broaden the scope of whom I’m able to reach.</td>
<td>For Tom, the professional role is concerned with making a positive impact on others. Connected to his goal orientation, he considers how his role can evolve and his work can impact a greater number of people as he progresses through the professional lifespan.</td>
<td>I’m looking at that role growing to an entire-hospital-research-director type of role….</td>
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</table>
Like the preceding table, the table below includes lines from Tori’s “I Am” poem. Lines from the poem, and the illustrative transcript excerpts coupled with them, show how the poem speaks to the research question. The “I Am” poem is representative of the ways Tori makes sense of her clinical educator role. The middle column of the table articulates how specific lines from the poem connect to the ways Tori makes sense of her role.
**Table I.2: Evidence for Tori’s “I Am” Poem**

<table>
<thead>
<tr>
<th>Line from Tori’s “I Am” poem</th>
<th>How line speaks to the ways Tori makes sense of her clinical educator role</th>
<th>Illustrative interview transcript excerpt</th>
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<tbody>
<tr>
<td>I am positive and progressive.</td>
<td>An essential aspect of Tori’s clinical education work is ensuring that she is a positive influence for novices. She is intentional in considering how she can make realistic progress in all aspects of her work.</td>
<td>Probably my enthusiasm. I’m a progressive thinker. I always want to think progressively, “What can we do to make it better?”</td>
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<td>I wonder if I negatively impacted those who came during my early years. I hear myself saying the wrong thing: “Read it again. Just read it again. Read. It. Again.”</td>
<td>Reflection is an integral part of Tori’s practice. An essential feature of that reflection is ascertaining whether or not her practice positively impacted students, as positive impact is the aim of her professional practice.</td>
<td>Did you impact students positively or negatively? I had to constantly ask that question to myself as I was going through the process. Everything that I did, “Am I impacting students positively or negatively?” Because you can impact them negatively. I didn’t think you could, but in that process, I realized, yes, you can impact them negatively. Even if you’re best intentioned….</td>
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<td>I see that I need to be better for these kids.</td>
<td>Tori understands that in order to continuously, positively impact the populations she serves she must continuously seek out professional development opportunities that will positively impact her practice.</td>
<td>Ten years in I thought, there’s got to be something more to teaching than this. I decided to do my National Boards…. I said, “I just wish I could do more to reach some of these kids.”</td>
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<td>I want to go back and respond again. Just respond again. Respond. To them. Again. Differently.</td>
<td>Connected to Tori’s reflective practice, she does not stop thinking about particular learners she worked with in years past. As she continues improving her own professional practice, she wishes she could go back to some learners and re-teach them.</td>
<td>I remember stating that I’d like to go back to these kids and go, “I am so sorry. Can you come back? Come back. I’ll take you all back.” …but those first 10 years I would stand and say, “Just read it again. Just look at it again. Go slower.”</td>
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<td>I pretend I am Carol. Asking what needs asking. Leading.</td>
<td>In her clinical educator role, Tori has taken things she learned from Carol and adapted them to suit her and her personality. From Carol, Tori saw the potential in taking leadership roles; it is an important part of her role to be active in committees so that she can help affect change.</td>
<td>(A) To this day, I still hear her in my head but it took me a while, at that time, for my age. She’d always ask me, “Why, why, why.” She’s always asking, “Why.” I got to the point where I did not like the word “why” because I felt like I just explained it to you and then she’d come around and she asked me the same question about why,</td>
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<td>I feel a sense of pride. Teaching is a profession.</td>
<td>Tori takes her professional role seriously and feels strongly that achieving excellence in it calls for dedicated, extensive periods of time. She asserts that achieving excellence in the professional role entails substantive teacher talk.</td>
<td>why, why…. She learned what I was thinking by asking that constant question. That’s how she learned about what I was processing…. I vowed I would never ask that question to my intern…and then I’ll catch myself asking why…. That was her way of getting me to start understanding what I was doing. “Why that approach Tori? Why did you do it that way? Why didn’t you do it this way?”</td>
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<td>I touch my failures—still fresh. Humility envelops me.</td>
<td>Tori does not grow complacent in her professional role. Reflective practice helps keep her grounded in the fact that she must continue refining her professional practice. Her reflexivity and humility come together to help her pursue excellence.</td>
<td>(A) It’s not just an hour. It takes a few days. It’s a constant collaboration at our teacher talk…. (B) …there isn’t any real talk about our practices as a CT…. It’s a sparkle dinner and they think doing that and giving us a gift bag... Talking about that with the CTs and the universities and what has changed and what they’re looking for, we do very awful.</td>
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<td>I worry I will be too harsh. They won’t learn. Striking the right mix.</td>
<td>Enacting her clinical educator role, Tori considers the ways she felt as a novice. She is also mindful of things like novices’ ages. These considerations are helpful in Tori’s efforts to maintain productive relationships with novices.</td>
<td>I tell them I have a coach as well. Everybody, I think, needs a coach. Somebody to help you be a better person because nobody’s perfect. Some of them are mature enough to see that. Some of the younger ones, not quite as much yet. It’s that fine line if they don’t take constructive criticism too well.</td>
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<td>I lament lost opportunities.</td>
<td>Tori understands that substantively thinking about and doing clinical education calls for substantial amounts of time. She is intentional in ensuring that a lack of time does not incapacitate her clinical educator role.</td>
<td>Time is definitely not on our side. We have to create that space of talking to them for those missed opportunities. It’s all on how you schedule the time. It’s important…. If you’re going to be a CT…it’s more than just meeting with them once a week, I feel, in order for that to be successful for them, for you, and, most importantly, for those kids.</td>
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<td>I understand their struggle. I say I’ve been there too.</td>
<td>Tori is intentional in letting novices know that she has experienced challenges similar to theirs. In this way, she shows humility, supports the relationship, and helps make it apparent that perfection and excellence are different.</td>
<td>It’s not always going to work out your way. I tell them I’ve had these experiences as well.</td>
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<td>I dream of the day they are willing to teach me.</td>
<td>Tori is concerned with teaching novices in ways that support her ability to give them increasing levels of autonomy. As novices’ knowledge and skills develop, they can enact the professional role with increasing independence. She knows she has achieved her goals with novices when she observes them successfully, independently teaching.</td>
<td>(A) We all have a conversation and I have the preservice, the first-year teachers, and the interns on Friday afternoons in my classroom. It’s great to hear their perspectives, and I have them talk to each other. (B) Knowing that I can meet them at professional meetings and ask them what they’re learning, what they talked about. It’s definitely refreshing to me….</td>
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<td>I try to sustain collegiality. Back and forth.</td>
<td>For Tori, the clinical educator role entails nurturing a support system within the classroom environment. In this way, she works to eliminate the hierarchical nature of the classroom and of the cooperating teacher/student teacher relationship. She focuses on ensuring all members learn from one another</td>
<td>My mission is that the classroom is open to learn, to work together, to collaborate, to learn from each other, and to learn from the kids. That’s what I really would hope is the ultimate goal, that we can have classrooms that would do that, so that we can go back and forth with each other.</td>
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<td>I hope I support them in the right ways.</td>
<td>Tori sees being a support to novices as a primary concern of her role. She is intentional in her efforts to ensure that novices understand she is focused on supporting them throughout the clinical practice experience.</td>
<td>I tell them it takes time. It really does. It’s something we will work on, and we’ll work on one thing. Let’s focus on one thing. There’s a lot of expectations. I’m there to support…but let’s work on one thing. You decide. What do you want to work on? The next time, let’s work that together.</td>
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