In an era in which our profession faces a personnel shortage, the retention of experienced occupational therapists is a timely and critical issue. Bailey's (1990) study of the reasons why occupational therapists have left the field documented that attrition is a serious problem for the profession and for the facilities and persons it serves. Bailey noted that “the largest group of survey respondents who have left the profession [35%] did so after 5 to 10 years in practice” (p. 37). With therapists leaving the profession so early in their careers, we are confronted with a shortage of experienced therapists to serve as role models, supervisors, and mentors for newer staff members. One way that we can increase the retention of experienced therapists is by creating incentives. Innovative staff development programs may serve as a viable, practical, and economical strategy to address attrition and retention.

Like many other health care professions, occupational therapy offers little career mobility. Many staff members believe that if they are competent, they will receive recognition and benefits by promotion into managerial positions. Such promotions, however, take them away from clinical practice. Thirty-one percent of the respondents in Bailey's (1990) study identified poor opportunities for career advancement as a major reason for leaving the profession. The biggest complaint was that our profession is two-tiered, that is, it consists only of clinical staff and department director positions. Despite the existence of career ladders in some facilities, differentiation by salary, title, and responsibilities is limited. Through their years of practice, seasoned therapists have integrated knowledge and expertise but have received little recognition for their repertoire of clinical skills. The lack of experienced clinicians is particularly problematic when coupled with the complexity of today's health care environment. Cost-containment, greater pressure for productivity, shortened lengths of stay, and patients with complicated medical and social needs require the skills of experienced therapists (Brollier, 1985). In this increasingly complex environment, occupational therapists must develop the ability to critically analyze practice situations.

This need for critical thinkers has been a recurrent theme in our profession (American Occupational Therapy Association [AOTA], 1987, 1989, 1990; Cohn, 1989; Parham, 1987; Rogers, 1983; West, 1990). This need is reinforced by the fact that the best role models for new professionals are committed occupational therapists who use an integrated approach to practice (Christie, Joyce, & Moeller, 1985). Support for the development of clinicians who can analyze their practice and who are committed to providing quality care presents a challenge to supervisors and administrators alike. Such support can be partially provided through programs that focus on meeting the developmental needs of staff. Accordingly, the purpose of the present paper is to describe an approach to staff development.

Dreyfus and Dreyfus's (1986) five-stage model of skill acquisition is integrated with findings from the American Occupational Therapy Association/American Occupational Therapy Foundation Clinical Reasoning Study. This model is presented as an organizing framework for staff development. Strategies for the recognition and retention of experienced clinicians who can serve as mentors for newer colleagues are identified.
development in which reflection on and evaluation of ideas are encouraged, rewarded, and expected as a part of everyday performance. The various developmental needs of staff members as they move from novice to expert are described, as are methods that encourage continual reflection on and evaluation of practice.

Staff Development Concepts

Components for successful staff development programs are identified in the management literature. Traditional staff development programs generally consist of formal courses, workshops, conferences, or a series of in-service training events that teach isolated skills and procedures (Pecora & Austin, 1987). These programs focus on immediate gains and productivity as goals rather than on the long-range needs of participants (Kaufman, 1974). Even when supported by the organization, these approaches may not prove to be effective.

Lieberman and Miller (1979) claimed that an effective staff development program should be integrated with the organization’s goals and, equally important, integrated with the professionals’ goals. They suggested that we focus on the interface between the staff’s needs and values and the organization’s goals. One way to accomplish this is to use the work itself to stimulate and reinforce professional growth and development. Thus, if the conditions and content of staff development programs are realistic, supervisors will have a better chance of changing behaviors and attitudes. Variation of on-the-job activities to present challenges can create opportunities for self-assessment that provide a basis for ongoing learning. The department director and immediate supervisors play an important role in creating a climate that encourages such self-reflection (Kaufman, 1974).

Another component to be considered in the design of staff development programs is the use of role models, or mentors. This is one of the most powerful strategies available to us for shaping, teaching, coaching, and assisting future therapists (Cohn & Czycholl, 1991; Rogers, 1982, Sabari, 1985; Schon, 1983, 1987). Gitterman and Netter (1988) advocated coupling this notion of role modeling with peer learning to design staff development programs. They suggested setting up situations where staff with varying degrees of experience brainstorm to share their perspectives and ideas.

Conferences, workshops, or other forms of continuing education help clinicians broaden their knowledge base and develop advanced skills. Problems may arise, however, when clinicians have more than adequate knowledge and information about professional issues, strategies, techniques, and skills but simply cannot operationalize such knowledge. One objective of staff development programs, therefore, may be to turn knowledge into action. Analysis of practice can help clinicians break away from procedures and practice concepts that are viewed as fixed formulations and help restore abstractions to their original state. Supervisors can help other clinicians conceptualize patterns of practice, so that learning is not bound to the specific situation in which the learning took place.

To be effective for staff development, supervisors need a thorough understanding of both adult learning and career development. Adult learners are generally “independent, self-motivated learners whose experience orients them to practical issues” (Pecora & Austin, 1987, p. 135). They prefer to apply new knowledge immediately. Thus, effective staff development should focus on skills relevant to the job environment with frequent feedback on the effect of the staff member’s actions while the action is taking place (Knowles, 1980). Smith and Elbert (1986) supported this premise by stating that “learning must be integrated with action if training is to produce progress” (p. 129).

The Process Used for Analyzing Practice

The process for analysis of practice developed for the AOTA/American Occupational Therapy Foundation (AOTF) Clinical Reasoning Study, although not conceived as a staff development program, provided an opportunity for the application of some current staff development concepts, such as role modeling, peer learning, the provision of immediate feedback, and the creation of a climate in which the evaluation of ideas was rewarded. The study took place in the occupational therapy department at University Hospital in Boston, Massachusetts, and continued for 2 years. Initially, seven therapists, each with more than 5 years of experience and diverse backgrounds in occupational therapy specialty areas, began analyzing their practice and the reasoning that directed their choice of actions. The principal investigator, an anthropologist, was assisted by occupational therapy graduate students in a process that involved videotaping patient-therapist therapy sessions. Before and after the therapy sessions, interviews with each therapist were videotaped. In the pretherapy interviews, therapists described their work with the patient and imagined or hypothesized how the session would unfold. During the posttherapy interview, the therapists described what happened in the session and identified key points at which specific reasoning resulted in specific actions. Segments of these videotapes were then analyzed and discussed by the therapists themselves, researchers, and other area clinicians in formal study groups. During the second year of the study, an additional group of seven therapists, each with approximately 1 year of experience, joined the study. Because the researchers conducted separate groups for the novice and experienced therapists, we were able to explicate the differences between the reasoning processes of novice and expert clinicians.
Novice to Expert

Integration of the findings from the Clinical Reasoning Study with Dreyfus and Dreyfus’s (1986) Model of Skill Acquisition provides an organizing framework for a staff development program. Dreyfus and Dreyfus identified a developmental continuum for growth that involves five career stages: novice, advanced beginner, competent, proficient, and expert. The stages represent increasingly complex ways of responding to practice. Data from the Clinical Reasoning Study demonstrate how these stages apply to the development of occupational therapists.

Stage 1: Novice

The novice recognizes various facts and features relevant to the acquisition of new skills and learns rules for determining actions based on those facts and features. Elements of the patient’s disability to be addressed in occupational therapy are so clearly and objectively defined for the novice that they are recognized without reference to the overall situation in which they occur (Dreyfus & Dreyfus, 1986). These elements are called context-free, and rules are applied regardless of what else is happening, that is, they are applied in isolation. For example, novice occupational therapists are taught how to assess joint range of motion, muscle tone, or balance and are given rules for how to conduct these procedures. They learn to identify what is normal and what is not, but generally do not consider other aspects of a disability, for example, the effects of joint range limitations on function. Because novices have limited experience with the situation they face, they must be given rules to guide their performance. Consequently, they judge their performance by how well they followed the rules.

In the AOTA/AOTF Clinical Reasoning Study, the novice clinicians focused primarily on objective findings, observable signs, and rules by which to make decisions (Cohn & Czyzcholl, 1991). Their reports about patients typically included information recalled from course work. They recalled characteristics of the clinical conditions studied and matched them to their patients. For example, a therapist unfamiliar with the diagnosis of Parkinson disease might read a reference to learn about the symptoms of this illness, yet fail to recognize that the symptoms, such as bradykinesia, will affect the patient’s ability to perform routine tasks.

While reflecting on her own development, a relatively new clinician recalled her interactions with patients. She reported that she saw the medical conditions first because she believed that was what she was hired to do—treat the medical condition. She stated, “Once I get my skills down, I can then focus on the interaction.” After she became comfortable with the medical focus, she felt free to focus on the patient as a person. Thus, we see that novice occupational therapists focus on context-free elements, that is, the disease processes, free from the context of the patients who have these diseases.

Stage 2: Advanced Beginner

Once novices gain more experience with patients, they learn to consider additional cues, which enable them to consider elements that relate to the patient as an individual. Dreyfus and Dreyfus (1986) called this new element situational, in which rules for skill acquisition include both situational and context-free components. For example, occupational therapists at this stage are beginning to consider patients’ occupational performance in the context of their patients’ expected discharge environment. Advanced beginners recognize the presence and absence of behavior but are not yet able to attach meaning to it, because they are still searching for familiar patterns to assist in problem identification. At this stage, they are still unable to determine priorities. To further clarify this point, try to visualize a patient with spatial perceptual problems performing self-care. The advanced beginner may recognize spatial perceptual impairment in a patient performing self-care but fail to realize that the patient’s inability to learn compensation techniques for self-care may be due to a poor attention span as well as decreased motivation. The advanced beginner does not yet see the entire picture.

A relatively young therapist involved in one of the Clinical Reasoning Study groups explained that she structured her treatments according to a framework she learned in school, that is, she had developed a structure to organize her observations for herself. She had a limited ability to sort out significant data, however. The therapist was so focused on the patient’s weak right arm that she decided “not to do anything with the other arm because it was okay.” However, the patient’s potential to function was based on compensatory training of the unimpaired arm. This example illustrates that the therapist was still unable to see the patient’s priorities.

Stage 3: Competent

A competent practitioner, according to Dreyfus and Dreyfus (1986), still “sees the situation as a set of facts” (p. 24). Not only do competent practitioners see more facts, but they are also able to identify which facts or observations are relevant. This recognition of crucial facts allows the competent practitioner to determine which aspects of a patient’s conditions are most important at a given time. Although competent therapists are able to individualize therapy based on their broader understanding of a patient’s problem and are able to handle multiple patient care demands with a feeling of mastery, they lack the flexibility and creativity that characterizes more experienced therapists’ work.

Elstein (1978) found that the identification of cues
and the generation of multiple hypotheses were two traits demonstrated by successful clinical decision makers. He also found that persons who could gather multiple cues were also able to construct several hypotheses and hold them in abeyance in order to gather additional cues to evaluate the various hypotheses. In the Clinical Reasoning Study, the experienced therapists were able to attend to more patient cues than were novices. They also constructed many hypotheses and seemed to anticipate the need to formulate these hypotheses on a temporary basis. They understood that their initial image of their patients would change as they collected more data. As their images changed, they in turn revised their initial therapy plans.

Stage 4: Proficient

Proficient therapists perceive a situation as a whole rather than as isolated parts. They have a sense of direction and a vision of where the patient should go, and they are able to take steps toward that goal. Proficient therapists are able to recognize and deal with unfamiliar situations and consider options, because they have the experience-based ability to recognize the nuances of a clinical problem. For example, a proficient therapist was able to adapt her handling of a baby addicted to cocaine when she realized that the baby was reactive to tactile input. Consequently, her treatment approach changed dramatically. Proficient therapists are able to see the whole condition. Experience helps proficient therapists identify what typical events to expect in a given situation and how plans need to be modified in response to these events. Proficient therapists can also recognize when the expected picture does not materialize.

By simply learning the diagnosis, such as cerebellar malfunction, the proficient therapist forms a specific mental image of the person who has this problem and selects evaluation procedures accordingly. The therapist will also hypothesize about the patient’s response to therapy before meeting the patient. Once the evaluation is completed, the proficient therapist will modify the initial hypotheses based on unexpected findings.

For the proficient therapist, certain features of a situation stand out as salient and others recede into the background. Once the important elements are identified, the proficient therapist then thinks analytically by combining rules and guidelines to make decisions. As therapy progresses, the salient features, treatment plans, and expectations are modified. No deliberation occurs— it appears just to happen as the therapist draws from similar experiences that trigger plans that have worked in the past and may be reapplied to new situations. Experienced therapists have a mental library full of experiences, whereas novices or students do not (Benner, 1984, Dreyfus & Dreyfus, 1986 [Note. Benner’s study of nurses was based on Dreyfus and Dreyfus’s original work. Benner’s study was published in 1984, whereas Dreyfus and Dreyfus did not formally publish their work until 1986.]).

In the Clinical Reasoning Study, we observed that novice therapists felt less comfortable revising their plans than did experienced therapists. Newer therapists worked hard to develop a treatment plan and were less likely to alter it when they confronted obstacles, whereas proficient therapists seemed to revise their plans automatically.

Stage 5: Expert

Expert therapists use rules and guidelines in a manner completely different from the novice therapists. The rules shift to the background. Experienced therapists appear to have an “intuitive grasp of each situation and zero in on the accurate region of the problem” (Benner, 1984, p. 32). In this context, intuition refers to a thorough understanding of a situation based on reflections of experiences. Intuition is not irrational, unconscious, or guesswork, but rather, the product of situational involvement and recognition of similarity. The rules, then, are unhitched to the sequence in which they were learned and are applied and adapted to a new situation more easily.

In the Clinical Reasoning Study, experienced therapists intuitively knew when to push a patient toward a higher level of function and when to let go to avoid failure (Mattingly, 1988). For example, an expert therapist intuitively knew when to set limits to increase tolerance for structured therapy. This intuitive judgment is based on correct identification of relevant cues at a particular time in the patient’s therapy, and a variety of medical, physical, and psychosocial factors are considered. Expert therapists recognized rules but moved beyond the rigid application of these guidelines based on an inner sense of knowing what to do next. “When things are proceeding normally, experts don’t solve problems and make decisions; they do what normally works” (Dreyfus & Dreyfus, 1986, p. 31). However, when confronted with obstacles or new situations, expert therapists demonstrated the analytic abilities described above.

Summary

This continuum of a professional’s career can be used as a basis for the design of an effective staff program that influences professional growth from novice to expert. Regardless of their experience, all clinicians may benefit from reflecting on their practice. Experienced staff can instruct those with less experience by example. Because experienced staff may have limited opportunities for advancement in occupational therapy, which is a two-tiered field, sharing their expertise with others in a public forum offers them some recognition. Novice staff members can benefit from observing the broad repertoire of strategies that the proficient and expert clinicians use to engage
patients and to reach their collective goals. Other benefits include heightened awareness and interpretation of cues that influence clinicians' actions, identification of successful therapy strategies, and alternatives for meeting treatment goals, all of which lead to a broad approach to practice.

Staff Development Using Case Stories

The basic elements of the process used to analyze practice in the Clinical Reasoning Study were integrated into departmental staff meetings at University Hospital in Boston. Case stories were created around the process of therapy. Some of these stories involved reports of the constant revision of therapy over time or how the patient and the therapy changed. Textbook descriptions of patients' clinical conditions and a listing of short-term and long-term goals were avoided to make the case stories more meaningful. Clinicians selected a therapy session to videotape, then chose a brief segment of that session and identified a number of leading questions to structure the group discussion. These questions included (a) identification of treatment strategies that were or were not successful, (b) identification of points in the therapy session in which the therapist confronted obstacles, (c) naming of the story of the session, (d) identification of choice points where changes in the therapy were made, and (e) "Who is this patient and what does he or she care about?" (i.e., what brings meaning to this patient's life?).

Staff with all levels of experience as well as any students present in the department met so that differing viewpoints, comments, or alternatives could be shared freely among them. As might be expected, staff responses to the process-oriented case story format generated concerns that generally correlated with their stage of professional development. Novice therapists focused on concrete skill acquisition. For example, they enjoyed seeing someone else in action; hearing others in the group discuss alternative approaches, challenges, and techniques that were used when the clinician got stuck; or seeing other specialty treatment areas. Experts, on the other hand, seemed more interested in observing how clinicians engaged their patients. Additionally, the experts were interested in how clinicians create a future with and for their patients, whether there were conflicts in the stories, and how the illness experience affects the patient. These clinicians focused on the more phenomenological aspects of occupational therapy. Although the clinicians viewed and integrated video segments on different levels, they all gained knowledge and benefited from open professional discussions, which often went beyond the specific cases to broader issues affecting the practice of occupational therapy.

Clinicians who had been videotaped articulated tangible ways in which they thought videotaping and analyzing practice in reflective study groups changed their thinking and their approach to practice. Changes noted among clinicians included increased personal insight into their response to patients, increased ability to take a reflective stance toward their practice, different approaches to analyzing and labeling observation, and improved ability to hypothesize about therapy outcomes. These enhanced skills were also observed in supervision. Clinicians became more adept at articulating their own reasoning process. In supervision sessions, the clinicians began to solve problems based on a broader perspective about what might have been happening in therapy.

Additionally, the process of analyzing videotapes vividly illuminated the complexity of practice and helped clinicians understand why fieldwork students struggle to put it all together. Supervisors were able to differentiate students' problems and restructure the learning experience to facilitate specific skills such as observation, identification of cues, generation of hypotheses, formulation of the patient's future, or engagement of the patient in a collaborative process. Acknowledging the complexity of practice helped clinicians appreciate what they were doing, stimulated their interest, and validated their professional identity. Many participants articulated that the very process of analyzing their practice renewed their interest in, enthusiasm for, and pride in the profession of occupational therapy.

Recommendations for Implementing Staff Development Programs to Facilitate Reflection on Practice

Although this staff development program evolved from a research project, other departments could easily replicate its essential components. Implementation of analysis of practice may be started with staff members who are interested in reflecting on and exploring their own practice. Participation on a voluntary basis would allow therapists to take the initiative and responsibility for planning their own professional development. Persons who volunteer could form two-member teams to interview, observe, and videotape each other. The teams could then meet in larger study groups. The study group leadership might rotate as each clinician showed his or her own videotape and structured the discussion and questions to his or her own developmental needs. Each leader might identify an interesting, difficult, exciting, challenging, or unusual therapy session to videotape and discuss. Another option would be to use an outside facilitator, such as a local occupational therapy faculty member, as a group leader. This facilitator could address potentially threatening situations that may arise as colleagues begin to share their philosophical and personal differences.
Some therapists might find this process threatening. To minimize this possibility, we recommend that supervisors serve as role models by showing that they are willing to risk making their own reasoning process explicit. That is, they must model the process and demonstrate that examination of one’s practice can be a rich learning experience. We believe that newer therapists will develop an understanding of their own reasoning processes by observing experienced therapists who question their own practice and by having permission to question others in a nonthreatening manner.

Before the videotaping sessions, the clinician is interviewed. He or she is asked to describe the patient from a narrative perspective, that is, to tell his or her story of the patient (Mattingly, 1990). The clinician is then encouraged to imagine what he or she expects to happen during the therapy session, what accomplishments might occur, or what difficulties might be encountered. Such open-ended questions facilitate a broad perspective and shift the focus away from a description of techniques and a listing of long-term and short-term goals. The clinician may construct a hypothetical story as he or she imagines the session will unfold.

After the videotaping, a posttherapy interview is conducted. The interview format might include a narrative description of what actually happened in the therapy session. The team may view the video together and generate specific questions. Topics of discussion might include specific techniques, patient–clinician interaction, key decision points in the session, frames of reference that inform the clinician’s thinking, challenges, surprises, and frustrations. The posttherapy interview serves to enhance clinicians’ awareness of what thoughts and actions guide their practice. The teams might then present their case stories to the study group or entire department for a larger discussion.

Given the pressure for productivity and tight schedules common to most occupational therapy departments, successful implementation of this program must be sensitive to time constraints. The process could be integrated into an existing scheduled meeting time during the day. Additional time for this process would be minimal if regular treatment sessions were videotaped and existing supervisory and staff meetings were used for study groups. Ideally, management staff with reduced productivity requirements, personnel from the hospital education department, or student volunteers could be used to videotape the therapy sessions.

Conclusion

We propose that ongoing reflection on practice in the work environment can help experienced clinicians serve as role models and mentors for novice therapists and remain enthusiastic and proud of their profession. This approach may also have a positive effect on staff turnover as therapists develop a renewed investment in their practice. Our experience with the staff at University Hospital has demonstrated the benefits of a process-oriented approach to staff development. By videotaping therapy as well as pretherapy and posttherapy interviews with therapists, followed by group analysis, we encouraged our clinicians to link thought and action in practice. This, in turn, can enhance the quality of care for patients.

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References


