Attitude development from the perspectives of occupational therapy interns and clinical educators

Kim Gerald Medallon[1]

Abstract: Attitude development is a component in the training of occupational therapy (OT) interns. Little attention is given to this construct in the Philippines. This study identified professional behaviors demonstrated by the OT interns, determined their consistency and extent of demonstration, and identified enablers and barriers for their consistent and full demonstration. This study utilized a qualitative design using observations, interviews, and review of documents. OT interns and clinical educators from a private university participated in this study. Descriptive and content thematic analyses were utilized. The professional behaviors demonstrated by the OT interns were considered narrow in scope. Most of the identified enablers and barriers were external to training. They provided the strongest influence on the interns. Implications: Instructional modifications need to be made to deliberately target this component in service delivery.

Keywords: behavior; professional practice; attitude; occupational therapy

1, University of Santo Tomas, Philippines

Adddress for correspondence: kgmedallon@ust.edu.ph

Date of first (online) publication: 30th Nobember 2022

Note: The abstract of this study was included in the proceedings of the 33rd World Conference on Applied Science, Engineering & Technology (Manila, February 2021) at which Dr Medallon gave an oral presentation.

Introduction

The final year in the curriculum of occupational therapy (OT) programs in the Philippines is intended for clinical training. OT interns are assigned in various practice settings, which include hospitals, schools, and community-based centers. Clinical training involves teaching and learning experience, as well as challenges (Hernandez, 2012). Clinical educators are responsible for implementing these programs which harness entry-level competencies. They ensure that a smooth transition from theory to practice is possible.

Health care professionals, like OTs, are expected to meet outcomes in a holistic, humane, and ethical manner. They should not only be knowledgeable and skillful but also altruistic and dutiful (Eckenfels, 2001). The concepts of professionalism and values-based practice emphasize these expectations and must be deliberately included in the training of health care professionals.

Professionalism may be viewed from the perspective of qualities, responsibilities, obligations, and ethical behaviors (Silva et al., 2019). Korthagen (2004) has a framework on professionalism consisting of six levels; namely: environment, behavior, competencies, beliefs, identity, and mission. Each of the interconnected levels plays a crucial role in maintaining a prudent discharge of professional functions. Specifically for OTs, the demonstration of professional behaviors and client-centered approach, along with professional values and ethics, professional responsibilities and relationships, image, communication, and collaboration, are vital tenets of professionalism (Lecours et al., 2021; Silva et al., 2019; Hordichuk et al., 2015). The shared set of values of a profession has the capacity to shape one's identity, strengthen client-centered approaches and interprofessional collaboration, and reduce ethical distress (Drolet & Desormeaux-Moreau, 2016).

Values-based practice involves an interplay of clinical skills, professional reasoning, service delivery models, and awareness of values (Merriman et al., 2020). Values encompass various motivational constructs such as preferences, needs, hopes, and expectations (Wieten, 2018). They influence a professional's decision-making process and demonstration of behaviors. Values form components of one's ideal self (Arieli & Sagiv, 2020). The collection of personal values affects an individual's preservation of personal and professional identity and evaluation of a situation, which in the health care setting affects client relations and provision of management (Fulford, 2011; Myyry et al., 2010).

Values-based practice is inextricably linked with person-centered care and evidence-based practice, which stresses a moral obligation to respect the uniqueness of individuals, acknowledge their values, and ensure that the line of care would be right, effective, and responsive to their contexts (Wieten, 2018). Contextualizing it in the OT profession, the wellbeing of clients takes a priority in the practice of the profession as influenced by the adoption of moral and ethical values (Silva et al.,2019). The principles of values-based practice, which are not prescriptive in nature, are useful guides for professionals when making decisions in situations characterized by competing interests and clashing priorities (Merriman et al., 2020; Cassidy, 2013).

Prioritization of values is a solid predictor to attitudinal and behavioral decisions of a professional in specific situations (Arieli & Sagiv, 2020; Fulford, 2011; Myyry et al., 2010). In addition, professional code of ethics is considered a strong antecedent to future actions (Lecours et al., 2021). Attitude refers to a state of readiness and preparation for action exerting a major influence on our responses to specific objects and situations (Insko, 1967; Rosenberg, 1960). These are manifestations of the soft skills or personality traits of an individual (Lecours et al., 2021). Behaviors, which are observable actions, as influenced by attitudes are demonstrated in the process. Professionalism in OT practice involves the demonstration of distinct attitudes and behaviors that support the service delivery (Lecours et al., 2021).

Attitudes are formed through repeated experience of responding to things, which may be facilitated by teaching-learning strategies. It is the role of the educator to facilitate the exploration of personal attitudes, along with deliberately teaching and assessing them (Kern et al., 2005; Howe, 2003; Lazarus et al., 2000). The expertise of an educator in harnessing attitudes is an interplay of various factors such as personal experience, pedagogical skills, and consistent modeling (Smith & Ragan, 2005; Howe, 2003). The demonstration of positive affection towards learners, tact of teaching, and overall responsiveness of the educator enhance the said factors (Sava, 2002).

Recommended teaching-learning strategies in developing attitudes include participant-centered discussions and peer influence (Howe, 2003), role playing (Lazarus et al., 2000), and case analysis (Smith et al., 2004). A positive learning environment, which is characterized by the adoption of adult learning principles, maximizes these strategies (Price & Mitchell, 1993).

Contextualizing this in the Philippine setting, Commission on Higher

Education Memorandum Order No. 52 Series of 2017 stresses that graduates of OT programs should practice professional, social, and ethical accountability and responsibility. Specifically, at the end of internship, a student should be able to deliver OT services in a professional manner with high standards of behavior. These standards affirm the necessity for affective outcomes to be emphasized.

Even if it is explicitly stated that they should be targeted, it is common knowledge that outcomes related to attitude development are considerably few compared to those targeting knowledge and skills. They are conventionally not being prioritized due to lack of confidence of educators. The same is true when it comes to evaluation. Lehmann et al. (2004) mirrored these predicaments emphasizing lack of allotted time in the curriculum and qualified educators.

This scenario necessitates the exploration of the root cause of the problem. Observation of professional behaviors can affirm the presence or absence of integration of affective outcomes, along with identifying enablers and barriers for professional behaviors to be consistently and fully demonstrated.

This study had the following objectives:

1. To identify the professional behaviors that are being demonstrated by the OT interns;
2. To determine the consistency and extent of demonstration of these professional behaviors; and
3. To identify enablers and barriers for professional behaviors to be consistently and fully demonstrated.

Method

Study design

This study utilized a qualitative cross-sectional design involving observation, interviews, and review of documents. It is exploratory and descriptive in nature and looks at the importance of context and the participants' frame of reference (Marshall & Rossman, 1989).

Sampling procedure

OT interns and clinical educators in the Philippines were the population of this study. The researcher had OT interns from a private university and OT clinical educators working in affiliation centers, within the National Capital Region, having formal linkages with the said university as the accessible population.

This study utilized purposive sampling in recruiting participants. With a purposive non-random sample, the number of participants is less important than the criteria used to select them.

Inclusion criteria for the OT clinical educators include:

1. Working in a hospital, school, or community-based center within the National Capital Region;
2. Supervising OT interns from the identified private university for at least one academic year; and,
3. Developed, revised, or implemented the clinical training program.

The researcher invited a clinical educator in a hospital catering to adults with physical dysfunctions, a clinical educator in a center catering to the children with psychosocial dysfunctions, and a clinical educator in a community-based rehabilitation center for the geriatric population. Direct observations, along with individual interviews with the clinical educators, were performed in these settings. The three settings presented unique factors influencing the teaching-learning process.

The OT interns came from the affiliation centers of the three clinical educators. To reduce bias, interns who had received clinical training under the supervision of the researcher were excluded from this study. From among the interns who were assigned in the affiliation centers, expert judgment was used by the researcher in choosing three interns for interview. The three OT interns, along with the other interns assigned in the same affiliation centers, were observed for this study.

Data gathering procedures

Ethical approval from the university's Ethics Review Committee was first obtained before the implementation of this study.

Direct observations were performed first. Before conducting them, the

researcher sent out letters of intention to the chief rehabilitation medicine doctors of the affiliation centers. The researcher gave an assurance that he will not influence the learning activities of the interns. In addition, the researcher sent out letters of invitation containing an overview of the study and certificate of consent to all the interns and clinical educators who will be observed and interviewed. The participants all signed these forms. Voluntariness, risks and benefits, and confidentiality were emphasized in the process. The researcher also informed the clients and the caregivers that the treatment sessions will be observed with which they all consented.

The OT interns and the clinical educators in each of the settings were observed for four hours in each of the two agreed upon dates. There were four OT interns and a clinical educator observed in each setting. In the four hours of observation per setting, the OT interns and the clinical educators were treating their assigned clients. The researcher kept a journal for his observation and interview notes. Observation notes contained everything that was perceived by the researcher during the numerous interactions of individuals inside the setting. Interview notes contained the statements given by the OT interns and the clinical educators at the end of the direct observation when the researcher probed on certain observations.

Interviews were then performed immediately after the direct observations. The interviews, running from 30 minutes to an hour, were semi-structured in nature. A sequence of open-ended questions was used by the researcher to be answered by the participants. A follow up on other themes of interest that have emerged during the interview and during direct observation was performed. Basically, the research questions were the major points of inquiry.

The interviews were audio recorded. The researcher also wrote down field notes as an additional source for comparative analysis. A research assistant transcribed the interviews. The researcher checked the accuracy of the transcription by listening again to the audio files. The transcripts were sent to the participants for member checking. All data were stored in computer files for analysis. Only the researcher had access to these files.

Documents such as the OT internship program of the private university, clinical training manuals, and syllabi of professional courses were also reviewed after the interviews. This was done to countercheck statements of the participants, specifically on identified enablers and barriers for professional behaviors to be consistently and fully demonstrated.

Data analysis procedures

The data gathered from the interviews were analyzed using a thematic content analysis process, which involved coding for thought patterns. Using this process, series of codes were generated from the transcript. Thought patterns emerged which may be grouped into categories. Frequency count of the emerging thought patterns was performed. Constant comparative method, as a verification procedure, was utilized.

For the data gathered from direct observation, the researcher first made a narrative summary. This was based on his observation and interview notes. A descriptive method of analysis was then used to elaborate the presence, consistency, and extent of demonstration of these professional behaviors. For the data gathered through review of documents, the researcher first made a narrative summary. This was based on the comments that he wrote on his journal. A descriptive method of analysis was then used.

Findings

From here on, the researcher used codes to refer to the participants. Participants were coded using letters to identify the type of setting where they were observed and interviewed. 'A' refers to the hospital setting. 'B' refers to the pediatric center. 'C' refers to the community-based center. Participants with '1' in their code names were both interviewed and observed. Participants containing other numbers in their code names were just observed. Table 1 and Table 2 contain the profile of the OT clinical educators and OT interns, respectively.

Table 1
Profile of the OT clinical educators

Code Name	Age	Gender	Years of Practice	Setting
CS A1	28	Male	6	Hospital
CS B1	35	Male	13	Pediatrics Center
CS C1	24	Female	2	Community

Table 2
Profile of the OT interns

Code Name	Age	Gender	Setting
Intern A1	22	Female	Hospital
Intern B1	21	Male	Pediatrics Center
Intern C1	21	Male	Community

Professional behaviors that were both observed and reported are presented first to be followed by professional behaviors that were only observed and lastly professional behaviors that were just reported by an OT intern or a clinical educator. Descriptions on how the OT interns demonstrated them in the three settings are included. The next set of findings include the enablers and barriers for these professional behaviors to be consistently and fully demonstrated from the perspectives of the OT interns and the clinical educators.

Observed and reported professional behaviors

Professional behaviors that were observed and reported by an OT intern or a clinical educator include initiative, adaptation, collaborative practice, and authenticity and empathy.

Initiative

Three different forms of initiative encompassing behaviors of spontaneously helping others and personally maximizing the available learning opportunities were identified. The OT interns demonstrated an initiative to help a co-intern, an initiative to help clinical educators and staff members, and an initiative to learn.

Helping a co-intern prepare an activity, packing away materials, handling a co-intern's client, and sharing newly learned techniques were the specific behaviors observed and reported. In the hospital setting, demonstration of an initiative to help a co-intern was observed in Intern A3. She volunteered to draw an outline of figures to be used by Intern A1 for a coloring activity because no worksheet was available. Intern A1 also packed away materials that were not personally used by her.

During the interview with CS A1, such observation was affirmed when

he stated that one consistent professional behavior that the interns were demonstrating was helping co-interns. CS A1 narrated,

> *'We had an intern who just finished bedside duty and now it's a requirement for every intern to do daily notes even for outpatient. That specific intern had around five notes that she had to complete. At the same time, prior to closing, all interns have to perform aftercare and inventory. Her co-interns didn't hesitate, didn't have second thoughts to help. They just told her to finish her notes and leave everything to them.'*

CS A1 added that such behavior was not limited to mere packing away materials. On certain events when two clients were scheduled on the same time slot with the same intern, a co-intern, with no scheduled client, would volunteer to help.

An initiative to help co-interns was also demonstrated in the pediatrics center during a meal preparation activity. Intern B3 and B4 attended to clients, who were not officially assigned to them, to ensure a smooth facilitation of the group activity. This professional behavior was also demonstrated in the community-based center. Intern C1 taught his co-interns methods on performing scapular mobilization based on techniques that he learned from a student exchange program abroad.

Another form of initiative stressed by CS A1 during the interview was an initiative to help clinical educators and staff members. He described it as an emerging professional behavior. He recalled an event when he transferred a client from his room to the rehabilitation center for treatment and other clients were also arriving on the same time slot. He observed that interns, who were free, automatically approached him and just asked for his treatment plan. This professional behavior was however directly observed in the pediatrics center. Intern B3 volunteered to assist the special education (SPED) teacher who was having difficulty designing worksheets to be used in a group activity the following day.

Watching intently procedures performed by clinical educators and asking for treatment options were the specific behaviors reflective of an initiative to learn. In the hospital setting, an initiative to learn was demonstrated by Intern A3. She observed CS A2 fabricate a hand splint without being asked to do so. This was also demonstrated in the community-based center. Intern C2 and Intern C3 observed CS C1 perform stretching exercises.

Adaptation

Three different forms of adaptation were identified. The OT interns

demonstrated adapting the tasks, adapting one's use of self, and adapting the environment to meet the needs of the client. Use of self involves the OT's professional reasoning and conscientious display of behaviors in developing and managing therapeutic relationships (American Occupational Therapy Association, 2020).

In the hospital setting, Intern A1 demonstrated adapting the task to meet the needs of the client. She immediately allowed the child to enter the room to play even if she has not prepared yet the area. She just conceptualized an obstacle course activity using the child's toys to meet the set goals. The child enjoyed the task. In the pediatrics center, Intern B2 and Intern B5 utilized simple arts and crafts activities to target fine motor skills instead of resorting to manipulatives. The children enjoyed the activity and were quick to finish it.

Adapting one's use of self to meet the needs of the client was demonstrated in the pediatrics center during a group meal preparation activity. Intern B1's playfulness captured the attention of all the children given the complex cognitive demands inherent in the task. He adjusted the tone of his voice to keep the children focused coupled with continuous encouragement.

This professional behavior was affirmed during the interview with Intern B1. He said that he was adjusting his use of self and utilizing different therapeutic modes depending on the needs of the child. He also described that such professional behavior was consistently and fully demonstrated on various occasions.

Adapting one's use of self was also observed in the community-based center. While implementing an exercise program, Intern C1 and Intern C4 adjusted their manner of giving out instructions to their clients, who have physical and mental limitations. Deliberate efforts to simplify instructions, along with the presence of unceasing encouragement, were evident.

In the community-based center, adapting the environment was evident. Interns C1, C2, and C3 always asked their clients if they were comfortable with the room temperature so that they may adjust it as needed. They also asked their clients if they need blankets. The overall setup of the room of the clients was always modified depending on their needs. The demonstration of this professional behavior was affirmed by CS C1 in the interview.

Collaborative practice

Two forms of behavior reflective of collaborative practice were identified. The interns demonstrated inquiring procedures received by a client and collaborating on treatment options.

In the hospital setting, Intern A1 and Intern A4 inquired about the procedures performed by physical therapy staff members on their clients. In the community-based center, Intern C2 inquired about a feeding procedure performed by a nurse. Collaborating on treatment options was demonstrated in the pediatrics center. CS B1 stated that this professional behavior was demonstrated on occasions when the interns initiated collaborative talks with SPED teachers for their shared clients.

However, CS B1 added that the collaboration with SPED teachers was still a one-way process with only the interns giving out strategies. He said that this existing collaboration has not reached yet that point where both parties jointly discuss goals and overall outcomes. He added that this may be caused by the apprehension of some interns to talk to a full-fledged professional.

During the interview with CS C1, she said that collaborative practice is an emerging professional behavior. She said that the interns were starting to talk and share insights with other members of the rehabilitation team on treatment options; however, they still needed cues to conduct themselves in a more professional manner. She added that they still lacked assertiveness in explaining the domain of the profession.

Authenticity and empathy

Five different forms of authenticity and empathy were identified. The interns demonstrated acknowledging the client's current mood and status, acknowledging the difficulty experienced by a client, providing a treatment on a lighter note, ensuring an open communication line, and providing continuous regard.

In the hospital setting, Intern A2 initiated a conversation to a client, who was not assigned to him, before the treatment session. Intern A3 also asked the client and his family members how they were feeling before starting the treatment session.

In the community-based center, Intern C2 and Intern C3, during their free time, conversed with a client handled by Intern C1 while performing exercises. The two OT interns always asked the client how she was feeling while performing the exercises. They also answered random queries posed by the client.

In the hospital setting, Intern A1 acknowledged the difficulty experienced by the client when the latter was performing strengthening activities. She continuously encouraged the client until the end of the activity. Intern A1 also asked questions on the day-to-day struggles that the client was

experiencing related to handwriting due to her weakness.

When asked during the interview, Intern C1 said that he was constantly noting their difficulties related to work even outside the treatment area. Intern C1 reported,

> *'I think its demonstration is fairly consistent. It is attached to a personal characteristic or conviction that goes beyond clinical training.'*

In the hospital setting, Intern A1 started a treatment session on a lighter note by allowing the client to narrate important events that have transpired the other week while she was performing exercises. In the community-based center, Interns C1, C2, and C3 injected casual conversations with their clients during the provision of treatment.

In relation to ensuring an open communication line, Intern A1 said that she has already been demonstrating this behavior. She recalled that there were incidents when clients compared their progress with peers who were also undergoing therapy. Intern A1 said that she ensured her clients that they can just voice out their frustration and concerns. On her part, she unceasingly encouraged her clients to attain optimal functionality despite difficulties. For the other clients, she said that she allotted a substantial amount of Provision of continuous regard for clients despite of some factors was also an evident professional behavior. In the community-based center, Intern C4 courteously answered all queries of a client with Alzheimer's Disease even if the former has already addressed them. During the treatment provision, no changes in demeanor were noted on the part of the intern.

Observed professional behaviors

Professional behaviors that were only observed demonstrated by the OT interns include patience and resourcefulness.

Patience

Two forms of behaviors indicative of patience were identified. The interns demonstrated continuous provision of encouragement and prompting despite the presence of off-task behaviors and continuous attention to the needs of clients.

In the hospital setting, this professional behavior was demonstrated

by Intern A1 when she continuously encouraged and prompted the child to finish an obstacle course activity despite the presence of some unruly behaviors. She maintained her composure and did not resort to any form of unnecessary restraining.

This professional behavior was also observed in the pediatrics center. Intern B2 and Intern B3 continued to encourage their clients despite evident sensory integration issues such as continuous jumping, random pinching, and running around the room. The two OT interns kept their composure and just prompted their clients to finish the task at hand.

Continuous attention to the needs of the clients was evident in the pediatrics center. Intern B1 has not changed his tone of voice and manner of teaching even if he has already repeated for several times how to use measuring cups for a meal preparation activity.

This professional behavior was also demonstrated in the community-based center. Intern C4 proceeded with implementing an activity despite numerous complaints of a client with Alzheimer's Disease. No changes in demeanor were noted during this incident.

Resourcefulness

In the pediatrics center, resourcefulness was demonstrated by Intern B5. Given the limited tools and materials available in the center, she managed to come up with a simple arts and crafts activity made up of crumpled sheets of paper and glue. She also opted to use the remaining sheets of paper for other activities to target fine motor skills instead of throwing them away.

Reported professional behaviors

Professional behaviors that were only reported by an OT intern or a clinical educator include preparedness and punctuality.

Preparedness

In the hospital setting, preparedness was personally reported by Intern A1 during the interview as a professional behavior she is currently demonstrating. She said that such behavior encompassed various forms from preparing the needed materials and treatment area to discharge planning. Intern A1 reported,

'I need to go beyond the prescribed sessions here inside the facility. I should already have a foresight of what the client will perform at home. I need to prepare comprehensive and contextualized programs for them.'

Intern A1 added that this professional behavior was consistently demonstrated. She said that preparations for each activity were done even before a clinical educator will check them. In addition, she personally reminded her co-interns to do the same on several occasions.

Punctuality

In the community-based center, a professional behavior that was not directly observed but reported by CS C1 during the interview was punctuality. CS C1 said that punctuality was demonstrated consistently by all interns when reporting for duty.

Enablers for professional behaviors to be consistently and fully demonstrated

This section presents identified enablers of the OT interns and OT clinical educators for professional behaviors to be consistently and fully demonstrated. Personal factors outside the training programs such as personal convictions, upbringing, and beliefs were both identified by the OT interns and OT clinical educators as enablers. In addition, they both acknowledged the potency of immediate feedback in facilitating the demonstration of these professional behaviors. They also identified the presence of peers as an enabler to demonstrate these professional behaviors. The OT interns placed special emphasis on actual treating and sharing of anecdotes of the clinical educators as opportunities to further refine the demonstration of professional behaviors. Enablers identified by the OT interns are presented first followed by the enablers identified by the OT clinical educators.

OT interns' comments

The OT interns identified eight enablers, namely: personal convictions, upbringing and religious beliefs, immediate feedback of a clinical educator,

sharing of clinical anecdotes of a clinical educator, actual treating of a clinical educator, modeling by peers, provision of various teaching-learning activities, and overall internship experience.

Personal convictions were consistently identified as enablers by the OT interns. There were professional behaviors like demonstrating empathy which the interns considered to be personally driven. The interns agreed that a strong sense of conviction to immerse oneself totally in the service delivery was needed to understand the unique contexts of each client. Intern B1 said,

'For me, it is not something that you can learn or would come out of clinical training.'

An intern's upbringing and religious beliefs were also identified as strong sources for learning and demonstrating appropriate behaviors. The OT interns emphasized that the set of behaviors stressed in the formative years affect one's predilection to act in a certain way in the future. Intern B1 related,

'One's upbringing will really be pivotal. The values imparted to you by your parents, along with the teachings of your religion will be major influences to how you treat others.'

Meanwhile, Intern A1 emphasized the immediate giving of feedback of clinical educators as a crucial enabler. The reviewed clinical training manuals specifically listed feedback sessions as vital components in the overall training. Intern A1 added that personal accounts of the clinical educators allowed her to appreciate salient features of the service delivery. These accounts made her more reflective of her actions. Aside from these sharing of anecdotes, Intern A1 and Intern C1 also considered the actual treating of clients of clinical educators as an important enabler. Necessary professional behaviors were highlighted in these scenarios according to them.

Modeling was not limited to observing clinical educators according to the OT interns. They said that they had also been learning professional behaviors through observing their peers. They said that seeing their peers demonstrate these professional behaviors inspired them to do the same.

Provision of various teaching-learning activities stressing the importance of attitude development was identified as an enabler. The interns stated

that these learning opportunities augmented whatever was gained through client interaction. Reviewing the clinical training manuals, some teaching-learning activities related to attitude development were included such as journaling and collaborative feedback. The interns also identified seminars on professional patient handling offered during the term as an enabler.

Lastly, the interns considered the overall internship experience and not necessarily the direct instruction received during training as an enabler. The routine that was developed in the day-to-day accomplishment of internship tasks aided the consistent demonstration of professional behaviors even without the presence of a clinical educator.

OT clinical educators' comments

The OT clinical educators identified five enablers, namely: preference for a setting of an intern, personal convictions of an intern, upbringing and culture of an intern, consistent provision of feedback, and camaraderie of interns.

An OT intern's preference for a particular setting has been identified as an enabler. CS A1 said that the interns were observed putting more effort into their clinical performance, including conducting themselves more appropriately, if they prefer a certain setting.

Personal convictions have also been considered enablers. CS B1 stated that a personal sense of commitment prompts a consistent manifestation of responsibility. One's upbringing and culture have also been linked to how interns communicate and treat others in the setting. CS B1 said,

> *'If they are brought up with that kind of attitude then I think wherever they may go, they will be manifesting such.'*

Special emphasis was placed by CS C1 on the role of clinical educators. She said that a consistent provision of feedback may lead to the demonstration of professional behaviors. Interaction with peers was identified as an enabler. Helping co-interns was perceived to be a product of the camaraderie the interns had built during internship according to CS A1. Table 3 shows the summary of enablers for professional behaviors to be consistently and fully demonstrated.

Table 3
Enablers for Professional Behaviors to be Consistently and Fully Demonstrated

OT Interns' Comments	OT Clinical Educators' Comments
Personal convictions	Preference for a setting of an intern
Upbringing and religious beliefs	Personal convictions of an intern
Immediate feedback of a clinical educator	Upbringing and culture of an intern
Sharing of clinical anecdotes of a clinical educator	Consistent provision of feedback
Actual treating of a clinical educator	Camaraderie of interns
Modeling by peers	
Provision of various teaching-learning activities	
Overall internship experience	

Barriers for professional behaviors to be consistently and fully demonstrated

This section presents the identified barriers of the OT interns and OT clinical educators for professional behaviors to be consistently and fully demonstrated. Various issues related to delayed provision of feedback in correcting inappropriate behaviors were both considered by the OT interns and OT clinical educators to be barriers. The OT interns placed special emphasis on their lack of preference for a particular practice setting and client while the OT clinical educators emphasized the lack of thorough knowledge of interns on the characteristics of a particular setting as barriers. Barriers identified by the OT interns are presented first followed by the enablers identified by the OT clinical educators.

OT interns' comments.

The OT interns identified four barriers; namely: lack of preference for a setting, non-preference for a client, delay in correcting a behavior, and lack of deliberateness in teaching the topic.

Intern A1 and Intern C1 agreed that lack of preference for a setting served as a barrier for professional behaviors to be consistently and fully demonstrated. When treating clients, efforts were perceived to be greater in non-preferred settings. In addition, non-preference of an OT intern to treat clients with certain medical diagnoses was cited by Intern B1 as a barrier. Personal factors and complexity of the case contributed to this non-preference.

Delay in correcting a behavior was also cited as a barrier. Intern A1 added that a clinical educator not correcting immediately an action performed by an intern may be perceived as more detrimental than facilitatory. According to the interns, it was more complicated when they were asked to perform self-reflection first.

Another noted barrier was lack of deliberate teaching of attitude development, along with all the expected professional behaviors, during their first four years in college. Intern C1 reported that provision of opportunities to practice collaboration with other professionals, for example, was limited. Collaboration with other professionals was only given as a pointer to consider. Reviewing the syllabi of professional courses, content areas related to attitude development and interprofessional collaboration were not listed as major units of learning. Opportunities for actual collaboration with other professionals or students from other allied health programs during their first four years in college were not also present.

OT clinical educators' comments

The OT clinical educators identified four barriers; namely: lack of thorough knowledge of interns on the characteristics of a setting, limited time for observation and feedback, lack of openness of interns to feedback, and intern's actions dictated by grades.

CS B1 said that lack of knowledge on the characteristics of a certain setting served as a barrier. He said that the interns were not just attuned on how an OT really works in an educational setting. This resulted to feelings of discomfort, especially with relating with other professionals.

CS C1 stressed that a clinical educator not allotting sufficient time for observing interns and providing feedback may serve as a barrier. In connection with the provision of feedback, a factor cited by CS A1 that can impede a consistent demonstration of a professional behavior

is lack of openness of the interns to feedback. CS C1 affirmed this by stating that an intern who does not see the significance of asking for help or being helped by a clinical educator may result to an unpolished discharge of duties.

Lastly, CS B1 reported that an inconsistent demonstration of professional behaviors may be expected if the intern's actions were dictated by grades. Table 4 shows the summary of barriers for professional behaviors to be consistently and fully demonstrated.

Table 4
Barriers for Professional Behaviors to be Consistently and Fully Demonstrated

OT Interns' Comments	OT Clinical Educators' Comments
Lack of preference for a setting	Lack of thorough knowledge of interns on the characteristics of a setting
Non-preference for a client	Limited time for observation and feedback
Delay in correcting a behavior	Lack of openness of interns to feedback
Lack of deliberateness in teaching the topic	Intern's actions dictated by grades

Discussion

The findings showed that the three settings presented little variety in the set of professional behaviors demonstrated by the OT interns. Most of the professional behaviors that were observed and reported were in line with OT professional expectations such as managing clients with diligence, working in teams, and communicating properly (Lecours et al., 2021). The identified professional behaviors also mirrored constructs that OTs advocate such as holism and adaptation to facilitate occupational participation of clients (Drolet & Desormeaux-Moreau, 2016). However, the OT clinical educators frequently stressed that the interns still needed continuous cues and prompts to enact and demonstrate them consistently. The extent of demonstration of the professional behaviors may be described as narrower in scope than the affective outcomes listed in the training manuals and professional expectations. However, it may be noted that despite these limitations, they exceeded what were deliberately provided in training.

Themes from the interviews revealed that the training programs

did not provide the strongest influence for professional behaviors to be demonstrated. Findings from a study of Gale-Grant et al. (2013) affirmed this statement by stating that direct instruction was not a dominant influence on developing professionalism. Rather, the observed and reported professional behaviors were those personally stressed by the clinical educators and valued by the interns. Supporting this statement, Arieli and Sagiv (2020) mentioned that inherited and social factors often give rise to the formation of values which in turn predict behaviors. Within the OT service delivery, professional development is influenced by the dynamic interplay of personal and environmental factors, which include cultural influences (Lecours et al., 2021).

The responses of the participants revealed that developing and demonstrating professional behaviors involved an eclectic receiving and mixing of information from different sources such as anecdotes of clinical educators, peer modeling, family upbringing, and religious beliefs. Collinson (2012) affirmed this by stating that family and close associates exert a powerful formative influence when it comes to the development of values, attitudes, and behaviors. These external sources enriched the overall learning experience.

These identified factors that the interns possessed and experienced outside the formal training can reinforce or remove whatever was directly taught (Tsai et al., 2012). These factors can cause the demonstration of professional behaviors to be stable despite the presence of various barriers stressed in the interviews. They can also strengthen one's sense of obligation towards others, as well as ensuring authenticity in discharging various professional actions (Cohen, 2007).

Treated as complementary component, deliberate instruction as implemented by clinical educators and suitable role models can be viewed as a reinforcement to these identified factors outside of training (Thampy et al., 2012; Randolph, 2003). The positive predilection towards attitude development of the OT interns, as revealed in the interviews, can solidify its niche in training. This is supported by a study of Randolph (2003) which emphasized that professionalism and development of professional behaviors were considered by OT students as the most important elements of learning as one makes the transition from classroom to work environment. The interviews revealed their conviction to provide holistic and humane OT service delivery; however, learning opportunities for such were limited and incidental.

Inconsistencies in the demonstration of professional behaviors were

evident in the interviews. Issues on preferences for a particular setting or medical diagnosis were reported. This emphasizes the primacy of personal values, which are relatively stable over time, in predicting actions even in the presence of explicit codes (Arieli & Sagiv, 2020). However, within the milieu of professional practice, one should also acknowledge and value professional code of ethics, standards, and values to ensure balanced decision making and outcomes. The combination of a thorough understanding of the professional code of conduct, coupled with good clinical skills supporting a particular service framework and evidence, results to better decision making in the face of conflicting situations (Ebrulkiz et al., 2017; Cassidy, 2013). These are yet to be refined and stressed in the professional courses and clinical training programs of the OT interns.

Various barriers resulting to professional behaviors not consistently and fully demonstrated were identified. The limited emphasis given to attitude development in the professional courses and training programs of interns, along with inconsistent implementation of some listed teaching-learning activities, was a prevalent theme. Mason et al. (2014) affirmed this scenario by stating that developing professionalism among allied health professionals has received rather less attention. This limited view may cause the topic at hand to be compromised and further belittled in the process by stakeholders. Absence of a clear framework, as well as an automatic adoption of techniques from mentors due to limited opportunities, may further complicate the arduous process of harnessing appropriate professional behaviors (McNair, 2005; Gale-Grant et al., 2013).

Some features of the learning environment were also identified in the interviews as limiting. It may be attributed to the actual impairment of the client, limited materials, absence of other professionals, and limited opportunities for collaboration. These factors may limit the quality of contextualized interactions which facilitate the strengthening of professionalism (Burford, Morrow, Rothwell, Carter, & Illing, 2014). All these identified barriers should be addressed with responsive and effective actions for they may compromise the overall competencies of future occupational therapists.

The findings of this study may inform OT education programs on the identified gaps related to attitude development. Although direct instruction was not regarded as a strong influence, its complementary role in maximizing factors external to training cannot be discounted. Professional courses and clinical training programs need to be modified to emphasize the development of professional behaviors. This will ensure deliberateness

and constructive alignment in attaining the needed outcomes for entry-level practice. All of these changes will ultimately benefit clients receiving OT services since they will be ensured of a service delivery rich in theoretical rationale and refined by humanness.

This study has its limitations. The gathering of perceptions and observations were limited to the OT interns and clinical educators in a single private university. Such limitations may be attributed to financial and time constraints when the study was implemented. Future research may further explore this construct with a larger sample, along with corroborating findings from the perspective of the interns' educators in the university, clients, and members of the healthcare team.

Conclusion

This study identified professional behaviors which were demonstrated in three settings, along with their consistency and extent of demonstration. The settings presented little variety in the set of professional behaviors observed and reported. Generally, the OT interns demonstrated professional behaviors in line with professional expectations; however, they still needed continuous cues and prompts to enact and demonstrate them consistently. Their demonstration may still be considered as limited and narrow in scope. However, these professional behaviors went beyond what were deliberately provided in training.

Various enablers and barriers for a professional behavior to be consistently and fully demonstrated were identified. Most of these factors were external to the training programs which included personal convictions, upbringing, sense of camaraderie, and various preferences/non-preferences. Although the OT clinical educators stressed the importance of harnessing professional behaviors, its lack of emphasis during clinical training was evident.

The findings emphasized the importance of capacity building programs for OT clinical educators to facilitate the refinement of existing clinical training programs. Deliberate provision of ample teaching-learning activities and assessments emphasizing attitude development and demonstration of professional behaviors should be included in the implementation of courses inside the university and training programs during internship. All these recommendations would further complement the identified enablers by both the OT interns and clinical educators which are external to the offered training programs.

References

American Occupational Therapy Association. (2020). Occupational therapy practice framework: Domain and process (4th ed.). *American Journal of Occupational Therapy, 74*(Suppl. 2), 7412410010. https://doi.org/10.5014/ajot.2020.74S2001

Arieli, S., & Sagiv, L. (2020). Values at work: the impact of personal values in organisations. *Applied Psychology: An International Review, 69*(2), 230-275. https://doi.org/10.1111/apps.12181

Burford, B., Morrow, G., Rothwell, C., Carter, M., & Illing, J. (2014). Professionalism education should reflect reality: Findings from three health professions. *Medical Education, 48,* 361-374. https://doi.org/10.1111/medu.12368

Cassidy, B. (2013). Uncovering values-based practice: VBP's implicit commitments to subjectivism and relativism. *Journal of Evaluation in Clinical Care, 19,* 547-552. https://doi.org/10.1111/jep.12055

Cohen, J. (2007). Viewpoint: linking professionalism to humanism: what it means, why it matters. *Academic Medicine, 82*(11). https://doi.org/10.1097/01.ACM.0000285307.17430.74

Collinson, V. (2012). Sources of teachers' values and attitudes. *Educator Development, 16*(3), 321-344. https://doi.org/10.1080/13664530.2012.688675

Commission on Higher Education. (2017). *CHED Memorandum Order No. 52, s2017. Policies, standards, and guidelines for the Bachelor of Science in Occupational Therapy Education (BSOT) program*. Retrieved from https://ched.gov.ph/wp-content/uploads/2018/04/CMO-No.-52-Series-of-2017-Policies-Standards-and-Guidelines-for-the-Bachelor-of-Science-in-Occupationa-Therapy-Education-BSOT-Program.pdf

Drolet, M., & Desormeaux-Moreau, M. (2016). The values of occupational therapy: perceptions of occupational therapists in Quebec. *Scandinavian Journal of Occupational Therapy, 23*(4), 272-285. https://doi.org/10.1177/0008417421994377

Ebrulkiz, F., Otlu, B., & Arslan, U. (2017). Trainee psychological counselors' understanding of ethics. *International Journal of Humanities and Social Science Invention, 6*(2), 10-17.

Eckenfels, E. (2001). Learning about ethics: The cardinal rule of the clinical experience. *Medical Education, 35*(8), 716. https://doi.org/10.1046/j.1365-2923.2001.01008.x

Fulford, K. (2011). The value of evidence and evidence of values: bringing together values-based and evidence-based practice in policy and service development in mental health. *Journal of Evaluation in Clinical Practice, 17,* 976-987. https://doi.org/10.1111/j.1365-2753.2011.01732.x

Gale-Grant, O. Gatter, M., & Abel, P. (2013). Developing ideas of professionalism. *The Clinical Educator, 10,* 165-169. https://doi.org/10.1111/j.1743-498X.2012.00643.x

Hernandez, K. (2012). Unraveling clinical experience: Occupational therapy student's perspective. *Hong Kong Journal of Occupational Therapy, 22,* 96-99.

Hordichuk, C., Robinson, A., & Sullivan, T. (2015). Conceptualising professionalism in occupational therapy through a Western lens. *Australian Occupational Therapy Journal, 62*(3), 150-159. https://doi.org/10.1111/1440-1630.12204

Howe, A. (2003). Twelve tips for developing professional attitudes in training. *Medical Educator, 25*(5), 485-487. https://doi.org/10.1080/00034980120103423

Insko, C. (1967). *Theories of attitude change.* New York: Meredith Publishing Co.

Kern, D., Branch, W., Jackson, J., Brady, D., Feldman, M., Levinson, W., & Lipkin, M. (2005). Teaching the psychosocial aspects of care in the clinical setting: Practical recommendation. *Academic Medicine, 80*(1), 8-20. https://doi.org/10.1097/00001888-200501000-00006

Korthagen, F. (2004). In search of the essence of a good teacher: towards a more holistic approach in teacher education. *Teaching and Teacher Education, 20*(1), 77-97. https://doi.org/10.1016/j.tate.2003.10.002

Lazarus, C., Chauvin, S., Rodenhuaser, P., & Whitlock, R. (2000). The program for professional values and ethics in medical education. *Teaching & Learning in Medicine, 12*(4), 208-212. https://doi.org/10.1207/S15328015TLM1204_8

Lecours, A., Baril, N., & Drolet, M. (2021). What is professionalism in occupational therapy? A concept analysis. *Canadian Journal of Occupational Therapy, 88*(2), 117-130. https://doi.org/10.1177/0008417421994377

Lehmann, M., Kasoff, W., Koch, P., & Federman, D. (2004). A survey of medical ethics education at US and Canadian medical schools. *Academic Medicine, 79*(7), 682-689. https://doi.org/10.1097/00001888-200407000-00015

Marshall, C., & Rossman, G. (1989). *Designing qualitative research.* California: Sage Publications.

Mason, R., Vitkovitch, J., Lambert, R., & Jepson, J. (2014). Knowing about and performing professionalism: Developing professionalism in interprofessional healthcare education. *International Journal of Practice-Based Learning in Health and Social Care, 2*(1), 96-107. https://doi.org/10.11120/pblh.2013.00027

McNair, R. (2005). The case of educating health care students in professionalism as the core content of interprofessional education. *Medical Education, 39,* 456-464. https://doi.org/10.1111/j.1365-2929.2005.02116.x

Merriman, C., Chalmers, L., Ewens, A., Fulford, B., Gray, R., Handa, A., & Westcott, L. (2020). Values-based interprofessional education: how interprofessional education and values-based practice interrelate and are vehicles for the benefit of patients and health and social care professionals. *Journal of Interprofessional*

Care, 34(4), 569-571. https://doi.org/10.1080/13561820.2020.1713065

Myyry, L., Juujarvi, S., & Pesso, K. (2010). Empathy, perspective taking and personal values as predictors of moral schemas. *Journal of Moral Education, 39*(2), 213-233. https://doi.org/10.1080/03057241003754955

Price, D., & Mitchell, C. (1993). A model for clinical teaching and learning. *Medical Education, 27*(1), 62-69. https://doi.org/10.1111/j.1365-2923.1993.tb00230.x

Randolph, S. (2003). Evaluating the professional behaviors of entry-level occupational therapy students. *Journal of Allied Health, 32*(2), 116-121.

Rosenberg, M. (1960). *Attitude organization and change: An Analysis of consistency among attitude components*. Connecticut: Greenwood Press Publishers.

Sava, F. (2002). Causes and effects of educator-conflict inducing attitudes towards pupils: A path analysis mode. *Teaching and Educator Education, 18,* 1007-1021. https://doi.org/10.1016/S0742-051X(02)00056-2

Silva, L., de Almeida Troncon, L., & Panuncio-Pinto, M. (2019). Perceptions of occupational therapy students and clinical tutors on the attributes of a good role model. *Scandinavian Journal of Occupational Therapy, 26*(4), 283-293.

Smith, P., & Ragan, T. (2005). *Instructional design*. Oklahoma: John Wiley & Sons, Inc.

Smith, S., Fryer-Edwards, K., Diekema, D., & Braddock, C. (2004). Finding effective strategies for teaching ethics: A comparison trial of two interventions. *Academic Medicine, 79*(3), 265-271. https://doi.org/10.1097/00001888-200403000-00015

Thampy, H., Gwynne, C., Codd, R., & Burling, S. (2012). How to teach professionalism. *Education for Primary Care, 23,* 297-299. https://doi.org/10.1080/14739879.2012.11494125

Thistlethwaite, J., & Ewart B. (2003). Valuing diversity: Helping medical students explore their attitude and beliefs. *Medical Educator, 25*(3), 277-282. https://doi.org/10.1080/0142159031000100346

Tsai, S., Ho, J., Hirsh, D., & Kern, D. (2012). Defiance, compliance, or alliance? How we developed a medical professionalism curriculum that deliberately connects to cultural context. *Medical Educator, 34,* 614-617. https://doi.org/10.3109/0142159X.2012.684913

Wieten, S. (2018). What the patient wants: an investigation of the methods of ascertaining patient values in evidence-based medicine and values-based practice. *Journal of Evaluation in Clinical Practice, 24*, 8-12. https://doi.org/10.1080/13561820.2020.1713065