



**SCHOOL OF OCCUPATIONAL THERAPY  
THE UNIVERSITY OF WESTERN ONTARIO**

**CURRICULUM 2011**

**Implemented for First Year in September 2009  
Implemented for Second Year in September 2010**

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## Introduction

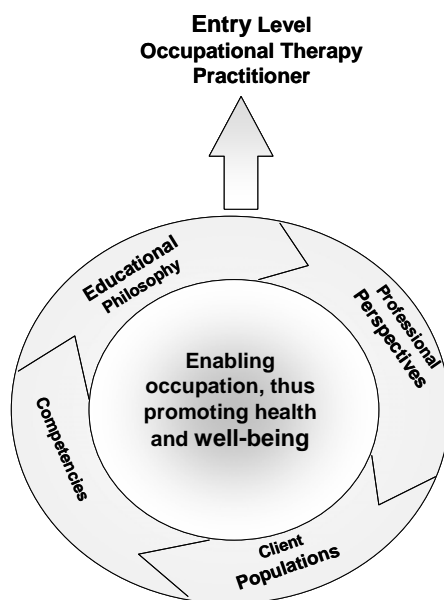
The **goal** of the School of Occupational Therapy curriculum is to develop practitioners who have the competencies and abilities to practice as entry level occupational therapists in a variety of practice areas. Moreover, this program is meant to develop the knowledge and attitudes that will allow graduates to continue to develop as practitioners, while working within a continually evolving health care context.

To achieve this goal, the **curriculum model** integrates a professional conceptual framework/philosophy and an educational conceptual framework/philosophy. These provide the foundation for the content and process of our curriculum. The **professional conceptual framework** is grounded by two core concepts regarding the role and function of occupational therapy, which are central to the profession: (1) occupational therapy enables meaningful human occupation, and (2) health and well-being can be promoted when occupational performance is enabled. Values and beliefs that underscore enabling human occupation in this curriculum are consistent with those outlined in Enabling Occupation II (Canadian Association of Occupational Therapists [CAOT], 2007, p. 3-4). This curriculum also supports the belief that participation in occupation is a human right and a social determinant of health and well-being.

The **educational conceptual framework** rests upon a philosophy that values social responsibility to the *self* and the *other*. Given this philosophical basis, the approach to teaching is *learner-centred*, wherein students are encouraged to take responsibility for their own learning and granted the opportunity to do so (Chornet Roses, McCabe, Hutchison, & Vita, n.d.).

The curriculum model also integrates client populations and competencies, as shown in the model depicted in Figure 1. Each of these four parameters will be discussed further later in this document.

**Figure 1. Curriculum Model**



The intent of this model is to allow faculty and clinical mentors/teachers to creatively enact teaching by using the four parameters to structure curriculum delivery as they draw on their expertise and occupational therapy knowledge, their personal strengths, resources, and their conscious reflections on the content to be delivered.

The model will be incorporated within the syllabus for each course, using a matrix for year one and then an advanced matrix for year two that includes practice contexts. Each syllabus describes the content of the course, the client populations addressed in the course, the educational philosophy used, and the practice objectives for developing competencies. The syllabi also explain which components are in the foreground (components that have a more prominent focus in the course) and which are in the background (components that are important to course context but not explicitly taught).

### **Year One Matrix**

Year one of the curriculum is comprised of the four parameters that are consistently used in the development of each syllabus. At the end of year one, the learning outcomes are to achieve the identified competencies at either a beginner or intermediate level, as defined on page 3 of this document. The parameters in the curriculum model year one matrix are defined and explained below.

### **Year Two Matrix**

Year two of the curriculum is comprised of four parameters that are consistently used in the development of each syllabus. At the end of year two, the learning outcomes are to achieve the identified competencies at an advanced level, as defined on page 4 of this document. The parameters in the curriculum model year two matrix are defined and explained below.

Figure 2. Curriculum Matrix – Year One

<b>Professional Perspectives</b>	Human Occupation	Occupational Science	Health & Rehabilitation Science	Critical Social and Cultural Perspectives	Client-centred Practice	Evidence-Based Practice	Ethical Practice	Reflective Practice and Clinical/ Professional Reasoning	
<b>Populations</b>									<b>Educational Philosophy</b>
Child/ adolescent									Dialogue
Adult									Responsibility
Older adult									Experiential Learning
<b>Competencies</b>	Expert in Enabling Occupation	Communicator	Collaborator	Practice Manager	Change Agent	Scholarly Practitioner	Professional	Knowledge of self and others	

Figure 3. Curriculum Matrix – Year Two

	Practice Areas	School	Mental Health	Acute	Rehab	Community	Private	Work		
<b>Populations</b>									<b>Professional Perspectives</b>	<b>Educational Philosophy</b>
Child/ adolescents									Human Occupation	Dialogue
Adult									Occupational Science	
									Health & Rehabilitation Science	
									Critical Social and Cultural Theories	
Older adult									Client-centred Practice	Responsibility
									Evidence-Based Practice	
									Ethical Practice	Experiential Learning
								Reflective Practice and Clinical/ Professional Reasoning		
<b>Competencies</b>	Expert in Enabling Occupation	Communicator	Collaborator	Practice Manager	Change Agent	Scholarly Practitioner	Professional	Knowledge of self and others		

## **Professional Conceptual Framework**

The professional conceptual framework, as discussed earlier, is rooted in the belief that participation in occupation is a human right and a social determinant of health and well-being. Occupational therapy practice draws upon diverse knowledge to enable occupation and promote the health and well-being of clients.

### **Professional Perspectives**

Eight different perspectives that provide the lenses or the foundation for understanding the work of occupational therapists are incorporated into this curriculum. These include theoretical and professional perspectives and fields of knowledge from human occupation, occupational science, health and rehabilitation science, critical social and cultural perspectives, client-centred practice, evidence-based practice, ethical practice, and reflective practice and clinical/professional reasoning.

#### **1. Knowledge of Human Occupation.**

Knowledge of human occupation in occupational therapy draws from a number of diverse fields, including occupational science, kinesiology, biomechanics, psychology, neuroscience, human development, cognitive science, social science, and rehabilitation science. Human occupation in occupational therapy is underscored by fundamental assumptions that occupation is a basic human need, occupation is therapeutic, engagement in occupation is essential to health and well-being, and occupation provides meaning to life. Occupational therapy's domain of concern is enabling occupation, and this may include all of the things that people do, and wish to do, in their everyday life. This may involve such diverse occupations as various forms of paid or unpaid work, the occupations of caring for self and caring for others, and/or creative and leisure occupations. Knowledge of enabling human occupation in occupational therapy is informed by an occupational perspective: that human occupation occurs in context as a result of a dynamic interaction of the person, occupation, and environment.

#### **2. Knowledge of Occupational Science.**

Occupational science is an interdisciplinary science focused on generating knowledge about human occupation (i.e., the range of activities people do) to inform policy, health care practices, evidence-based approaches, and organizational strategies to enable occupation and health at individual, community, and societal levels. This knowledge base informs the conceptual development and understanding of occupation for use by occupational therapists. In addition, it also provides research evidence on occupations and their dimensions, the various levels at which occupation occurs and is shaped (that is, at the level of the individual, the family, the community, society, and/or globally) across the lifespan, the meaning of occupation, how structural elements enable and/or constrain occupation, and the relationship of occupation to health and well-being.

### **3. Knowledge of Health and Rehabilitation Science**

#### **(Multidimensional approach to understanding health, functioning, & disability).**

Health and rehabilitation science is an interdisciplinary science that generates knowledge on functioning, disability, and health. In occupational therapy, this bio-psycho-social perspective of disability and functioning supports an understanding of the broader contextual and social determinants of health; the detailed knowledge of physical, emotional, and mental functional limitations that contribute to disability; and the societal and system restrictions that make it difficult to participate or conduct life sustaining or meaningful activities and occupations. As well, this knowledge helps advance a conceptual understanding of the opportunities for social participation that are mediated by contextual factors in the environment and by person factors.

#### **4. Critical Social and Cultural Perspectives.**

A critical social perspective draws attention to how the arrangement of social systems influences access to, and participation in, occupation. Occupational therapists are concerned with human rights and equal opportunity for persons with various abilities and disabilities. A critical social perspective recognizes that opportunities to engage in occupation are not always fair and balanced but rather are shaped by the ways in which social systems are organized and by cultural contexts. Critical social theory informs the notion of occupational justice, which calls for fair and equitable opportunities for all persons to participate in, and have access to, meaningful occupations. The search for occupational justice leads the occupational therapist to advocate for the rights of persons to participate in meaningful occupation. The addition of this perspective recognizes that rehabilitation and health, as well as the work of occupational therapists, are often constrained by contextual conditions.

A cultural perspective entails the examination of how world views and belief systems are intertwined to shape the way in which we see ourselves and others. It includes intercultural awareness, but also fosters tolerance and positive interchange. Language, traditions, mythology, and family relationships are some elements that play essential roles within one's culture. This perspective informs occupational therapy intervention in creating a culturally sensitive context where individuals can interact while having their values, customs, and world views not just acknowledged, but also protected against discrimination.

#### **5. Client-centred Practice.**

Client- or person-centred practice is one of the basic tenets of occupational therapy. This approach to practice aims to enable client autonomy through active participation in negotiating meaningful goals that serve to maintain the client's hope. To skillfully utilize this approach, therapists must truly listen to and show respect for clients and their goals and provide accessible services. The therapist and client form an effective working partnership that facilitates choice through a process of informed decision making. Clients are empowered to fulfill their required roles through a focus on their strengths, experience, and knowledge. This perspective of client-centred practice will inform the interaction of occupational therapists with clients in the delivery of service and care processes in practice.

## **6. Evidence-based Practice.**

Evidence-based practice is an approach to clinical practice that involves the integration of research evidence with clinical expertise and patient values (Rappolt, 2003; Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000) when making practice decisions. It involves using research evidence in consultation with clients and working collaboratively with clients in reviewing evidence and making informed decisions (Sudsawad, 2006). Although based on its original foundations with evidence-based medicine, researchers and clinicians in occupational therapy have adapted evidence-based practice to create a better fit with the nature of occupational therapy. For example, within the joint position statement on evidence-based practice published by CAOT, Association of Canadian Occupational Therapy University Programs [ACOTUP], Association of Canadian Occupational Therapy Regulatory Organization [ACOTRO], and the Presidents' Advisory Council (CAOT, ACOTUP, ACOTRO, & Presidents' Advisory Council, 1999), the intersection between evidence-based and client-centred practice is highlighted, with evidence based occupational therapy described as involving the client-centred enablement of occupation based on client information and critical review of relevant research, clinician expert and expert consensus. Thus, an evidence-based approach within occupational therapy involves drawing on information from various sources – including research, clinicians, and clients – in order to work with clients to enable occupation.

## **7. Ethical Practice.**

Ethical occupational therapy practice refers to carrying out the tasks and duties of one's professional scope of practice in a way that is not only technically proficient but that also honours the stories and lived experiences of both the therapist and the client; it involves relationships that are born out of deep and rich respect for others (Brockett & Dick, 2006). The Canadian Framework for Ethical Occupational Therapy Practice (Brockett & Dick, 2006) informs the development of a therapist's moral agency. This document describes ethical occupational therapy practice "as reflective, sensitive, mindful, courageous; considerate of laws and rules, professional codes of ethics and standards of practice; engaged in working towards health, healing or maximizing occupational performance of clients; aware and respectful of all other people involved in a professional encounter, striving to have everyone work together in a mutually beneficial relationship" (Brockett & Dick, 2006, p. 1).

## **8. Reflective Practice and Clinical/Professional Reasoning.**

Reflective practice is defined as a critical assessment of one's own behaviour as a means of developing one's own abilities in the workplace. It is a dialectical process in which thought and action are integrally linked (Schön, 1987). Educational literature describes practice, and especially theoretically informed practice, as "praxis" and suggests that it involves critical reflection and action upon the world. It is through practicing that people gain consciousness, freedom, and the possibility of transforming the world (Freire, 1989). In occupational therapy, this sort of theory-based practice/praxis is partially enacted through clinical reasoning, which involves the integration of clinical knowledge, self knowledge, and client knowledge. Occupational therapists use clinical reasoning to make decisions about the enablement skills they will use to collaborate with clients in order to enable occupation (Townsend & Polatajko,

2007). As part of this process, therapists continually evaluate and monitor their own interpersonal behaviour in order to engage the client in an effective therapeutic relationship (Taylor, 2008; Townsend & Polatajko, 2007). Clinical reasoning in occupational therapy is a synthesis of occupational reasoning and enablement reasoning, guiding critical reflection and actions with diverse clients in diverse contexts (Townsend & Polatajko, 2007).

### **Practice Areas**

The curriculum in the second year of the program is structured around seven practice areas, defined as follows:

#### **1. School.**

Occupational therapists address barriers to participation in active and health occupations for children and youth. A missed opportunity to support a child's development at any stage will have negative impacts across the life span. Occupational therapists work with children, parents or caregivers, schools, and community organizations to enable children to participate fully at school, home, or in the community. Occupational therapists analyze children's abilities, activity requirements, and the environments in which they do occupations, including classrooms, playgrounds, homes, and communities. Occupational therapists work directly with children and their families, as well as with schools and community partners, to restore and improve ability, prevent further disability, progress children toward targeted outcomes, develop routines, support transitions, promote integration, and build the capacity of families, schools, and communities to support the child (CAOT, 2009a; Cramm, Pollock, Dennis, Subramaniam, & Carkner, 2009).

#### **2. Mental Health.**

Occupational therapists work collaboratively with consumers, families, other professionals, and community support systems to create home, work and community environments that facilitate meaningful occupation and thus support mental health and well-being. This includes breaking down the barrier of stigma and provision of recovery-oriented care that enables meaningful lives for people in the community, despite the presence of intermittent or pervasive mental illness. Mental health intervention in the community is often delivered in the form of assertive community treatment (ACT), which provides inter-professional, long-term, innovative, and highly flexible services to people with severe and persistent mental illness in their own environments for as long as necessary (CAOT, 2008b; Kubina, 2000).

#### **3. Acute.<sup>1</sup>**

Occupational therapists working in acute care settings conduct assessment and treatment with individuals of all ages who are in hospital for a variety of medical or surgical conditions. Some out-patient follow-up may also be provided. This is a fast-paced practice environment where the emphasis is on getting the client medically stabilized and discharged home or to another

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<sup>1</sup> Despite an extensive search for published descriptions of this area of Canadian practice, none could be found in the literature. These descriptions met with consensus among faculty developing this document. It is our intent to consult with clinicians practicing in these areas for additional input.

level of care as quickly as possible. Clients with chronic illness or disability may be hospitalized for a short stay to establish a new treatment regime, and the same may happen for palliative clients. Occupational therapists working in this environment generally collaborate with members of a multi-disciplinary team.

#### **4. Rehabilitation.<sup>2</sup>**

Occupational therapists working in rehabilitation settings conduct assessments and interventions with individuals of all ages and may use groups to treat individuals with similar concerns. Rehabilitation services may be provided on a specialized unit within a hospital or in a separate rehabilitation centre. Such services are usually in-patient, but out-patient follow up may also be provided. The rehabilitation setting provides intensive therapy services, with a goal of optimizing function and returning the client to independent community living and full participation in the occupations of daily life. Clients often have a new chronic illness or disability, but those with a longer history may be admitted following a change in function to try to re-gain their former level of ability. Practice in rehabilitation settings is typically interprofessional.

#### **5. Community.**

Occupational therapists work in people's homes (including long term care settings), worksites, and community and family practice clinics. Occupational therapy services in the home and community promote health, prevent injury, and reduce the need for formal and institutional care, which can reduce health care costs, particularly for those who are aging, those with disabilities, and those with chronic illness. Occupational therapists also provide support services for friends and family who provide much of the care at home. Home and community care are part of the primary health system, where services are delivered where people live, learn, work, and play. Occupational therapists have demonstrated positive outcomes in primary health care roles working with seniors, children, youth, workers, homeless people, and those with mental health problems (CAOT, 2006; CAOT, 2008a).

#### **6. Private.**

Occupational therapists working in private practice settings conduct both individual and group therapy with clients of all ages. They may also provide consultation services. Private sector practice contexts include workplaces, schools, government bodies, communities, and health facilities. Services are provided on a fee-for-service or contract basis, outside traditional provincial health insurance schemes, paid for either by individuals or third-party payers. Typical third-party payers for private occupational therapy services include worker compensation boards, private insurers (especially auto insurers and long term disability carriers), and Veteran's Affairs. Examples of the services provided include case or disability management, return-to-work programs, hand therapy and splinting, stress management, caregiver education,

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<sup>2</sup> Despite an extensive search for published descriptions of this area of Canadian practice, none could be found in the literature. These descriptions met with consensus among faculty developing this document. It is our intent to consult with clinicians practicing in these areas for additional input.

assessment of care needs, prescription of assistive and mobility devices, injury prevention, pre-employment functional capacity evaluations, functional home assessments, play therapy, hand writing programs and medical-legal consultations. This is a challenging area of practice which can be more adversarial and litigious than public sector practice. Marketing and business management skills figure prominently in this area of practice (CAOT, n.d.; Ghosn, 2001; Kennedy, 2004; Sloggett, Kim, & Cameron, 2003).

### **7. Work.**

Occupational therapists consider the needs and concerns of workers, work teams, managers, unions, health and safety committees, and the organization when developing and implementing workplace health and return-to-work services. A comprehensive workplace health strategy encompasses the physical and social environment, personal health practices and resources, and the company's culture, policies, and work practices. Programs such as ergonomics, health and safety (including safety equipment), employee assistance, pain management, disability management, and injury prevention are examples of elements of workplace health strategies. Work/functional capacity evaluations are just one element of some return-to-work services, which may be delivered within or outside of the work environment (CAOT, 2004; CAOT, 2009b).

## **Client Populations**

This curriculum draws upon the life span and includes three sectors of the population: children/adolescents, adults, and older adults. These three groups reflect the healthy and vulnerable population groups and individuals with whom occupational therapists will work in practice.

## **Objectives**

*(Roles, skills, abilities, use of knowledge in practice and professionalism)*

This curriculum is moving towards a competency based evaluation model (Damron-Rodriguez, 2008; Harden, 2007; Harden, Crosby, Davis, & Friedman, 1999; Leach, 2008; Sharpless & Barber, 2009; Smith, Goldman, Dollase, & Taylor, 2007), in which the competencies that we want our graduates to demonstrate will be measured using appropriate outcomes. Development of a competency based model is a process that takes time to implement successfully (Litzelman & Cottingham, 2007); thus it is anticipated that this curriculum is not a static entity, but will be evolving over time as faculty gain experience with the model. At the present time, course objectives are to evaluate competency-based outcomes at three levels, based on definitions drawn from Benner (1982) and Smith et al., (2007):

- Beginner level - requires the ability to recognize, participate in, and reflect on the competency (Smith et al., 2007). At this level, knowledge is developing, but there has been no real opportunity to enact the competency.
- Intermediate level – requires the ability to take personal responsibility and enact a competency at a novice level as defined by Benner (1982). Benner describes a novice as having little or no experience with a situation, but knowing the rule to apply to guide action.

At this level, there is not enough real experience to make judgments about when a rule might not fully apply to a situation or when the rule needs to be modified to fit the context. At this intermediate/novice level, students will tend to focus on the bits and pieces of a situation versus the big picture.

- Advanced level – requires the ability to demonstrate independent action in enacting the competency, and corresponds to Benner’s advanced beginner level, the level at which most new graduates operate (Benner, 1982). At this level, the individual has enough experience to formulate general principles for action and to recognize aspects of a situation that requires attention but, as opposed to the “competent” practitioner, cannot yet quickly judge relative priorities of different aspects of clinical situations, nor deal with all nuances. The advanced beginner therefore may still require *some* support in the clinical setting (Benner, 1982).

The competencies in the curriculum are drawn, for the most part, from the Profile of Occupational Therapy Practice in Canada as outlined in the CAOT (2007) publication, as well as from the Canadian Model of Client-Centred Enablement (CMCE) as described in Enabling occupation II: Advancing an occupational therapy vision for health, well-being, and justice through occupation (Townsend & Polatajko, 2007). The seven competencies for “competent” occupational therapy practice identified in the Profile of Occupational Therapy Practice in Canada are included (expert in enabling occupation, communicator, collaborator, practice manager, change agent, scholarly practitioner, and professional), with the addition of an eighth competency labelled “knowledge of self and others”. It is beyond the scope of the curriculum to produce “proficient” therapists, so “proficient” competencies are not formally addressed in the curriculum and have not been included in this document. However, we do recognize that some students, based on their background, personal qualities, and their opportunity to engage in a senior placement combined with an elective and/or a research project in the same area, may edge into some areas of proficiency.

These competencies are more fully defined in the Profile of Occupational Therapy Practice in Canada as follows (CAOT, 2007, pp. 7-17):

## **E. Performance Expectations for “Competent” Occupational Therapy Practice**

### **E. 1 “Competent” Expert in Enabling Occupation**

- E. 1.1 Function effectively as a client-centred expert in occupation, occupational performance, and occupational engagement.
  - E. 1.1.1 Demonstrate expertise in occupations, occupational performance, and occupational engagement in practice with clients.
  - E. 1.1.2 Advocate for the client and occupational therapy to create positive first point of contact with client based on a referral, contract request, or the occupational therapists’ recognition of the real or potential occupational challenges.
  - E. 1.1.3 Incorporate the client’s perspective on meaning and relevance of needs and plans.

- E. 1.1.4 Establish positive therapeutic relationships with clients that are characterized by understanding, trust, respect, honesty, and empathy.
- E. 1.1.5 Demonstrate skills in client-centred practice including mediation, negotiation, awareness, and respect for client.
- E. 1.2 Recognize the limits of personal expertise.
  - E. 1.2.1 Demonstrate insight into personal limitations and expertise.
  - E. 1.2.2 Recognize situations where occupation, occupational performance, and related processes should be limited or discontinued.
  - E. 1.2.3 Demonstrate effective, appropriate, and timely consultation with other health professionals as needed for optimal client service.
  - E. 1.2.4 Arrange follow-up services for a client within their specific circumstances.
- E. 1.3 Perform a complete and appropriate assessment of occupational performance.
  - E. 1.3.1 Establish a shared understanding of occupation and occupational performance issues with the client.
  - E. 1.3.2 Engage clients to clarify values, beliefs, assumptions, expectations, and desires.
  - E. 1.3.3 Assess occupational performance in relevant areas, including self-care, productivity, and leisure; and within the context of roles, demands, expectations, goals and settings, and spiritual values of the client.
  - E. 1.3.4 Identify the client's strengths and resources.
  - E. 1.3.5 Identify the strengths and resources of the occupational therapist in relation to the client's needs.
  - E. 1.3.6 Assess cognitive, affective, connotive (e.g., meaning, values), and physical components related to occupation and occupational performance issues identified.
  - E. 1.3.7 Seek out and synthesize relevant information from other sources, such as family, caregivers, and other professionals.
  - E. 1.3.8 Use appropriate investigative methods in an effective and ethical manner throughout the assessment process.
- E. 1.4 Apply core expertise and professional reasoning.
  - E. 1.4.1 Apply relevant and current knowledge of the physical, social, psychosocial, environmental, and fundamental biomedical and social sciences to practice.
  - E. 1.4.2 Demonstrate sound use of relevant models, frameworks, and theories of occupational therapy.
  - E. 1.4.3 Demonstrate effective problem solving and judgment to address client needs.
  - E. 1.4.4 Mediate or negotiate common ground or agree not to continue practice process.

- E. 1.5 Synthesize assessment findings and reasoning to develop a targeted action plan.
  - E. 1.5.1 Analyze tasks and activities relevant to occupational performance issues.
  - E. 1.5.2 Determine resources required for service delivery while identifying any limits or constraints on the various service delivery methods.
  - E. 1.5.3 Identify priority occupational issues and possible occupational goals.
  - E. 1.5.4 Analyze physical, cultural, social, and institution environmental impact on occupational performance issues.
  - E. 1.5.5 Analyze and propose physical design options to increase inclusion and accessibility in the built environment.
  - E. 1.5.6 Formulate and document possible recommendations based on best explanations.
  - E. 1.5.7 With client participation and power sharing as much as possible, develop the desired realistic, measurable, understandable, and targeted outcomes consistent with client values and life goals.
  
- E. 1.6 Demonstrate skilled and selective use of occupation and interventions to enable occupation.
  - E. 1.6.1 Consult, advocate, educate, and engage the client through occupation to implement the process.
  - E. 1.6.2 Implement targeted action plans relevant to the person, occupation, and environment.
  - E. 1.6.3 Propose physical design options to increase inclusion.
  - E. 1.6.4 Incorporate cultural, social, physical, and institutional options to increase inclusion.
  - E. 1.6.5 Implement interventions in an effective and ethical manner.
  - E. 1.6.6 Adapt or redesign the plan as needed in monitoring progress regularly.
  - E. 1.6.7 Document conclusion/exit and disseminate information and recommendations for next steps (e.g., discharge, coordinated transfer, or re-entry).

## **E. 2 “Competent” Communicator**

- E. 2.1 Engage in effective dialogue.
  - E. 2.1.1 Demonstrate active listening.
  - E. 2.1.2 Deliver information in a respectful, thoughtful manner.
  - E. 2.1.3 Use plain language that is understandable.
  - E. 2.1.4 Respond to non-verbal cues.
  - E. 2.1.5 Employ approaches which encourage participation in decision-making.
  - E. 2.1.6 Appropriately communicate information related to the client’s occupational engagement and occupational performance.
  - E. 2.1.7 Adapt communication approach to ensure that barriers to communication (e.g., language, hearing loss, vision loss, inability to communicate verbally, cognitive loss) do not impact the client’s ability to direct their own care process.

- E. 2.1.8 Employ teaching aids, written materials, and other resources that support effective communication.
- E. 2.2 Convey effective written and electronic documentation.
  - E. 2.2.1 Use an occupation-based framework for documentation.
  - E. 2.2.2 Maintain clear, accurate, and appropriate records (e.g., written or electronic) of client encounters and action plans.
  - E. 2.2.3 Comply with applicable provincial regulatory and organizational document standards.
- E. 2.3 Support diversity in communication.
  - E. 2.3.1 Demonstrate sensitivity to client issues related to diversity and difference.
  - E. 2.3.2 Enable parties to openly communicate and consider other opinions.
- E. 3 “Competent” Collaborator**
  - E. 3.1 Work effectively in interprofessional and intraprofessional teams.
    - E. 3.1.1 Demonstrate an understanding of the roles and responsibilities of team members.
    - E. 3.1.2 Demonstrate a respectful attitude towards team members.
    - E. 3.1.3 Include the client as active team member whenever possible.
    - E. 3.1.4 Support positive team dynamics.
    - E. 3.1.5 Work with team members using shared decision-making to meet the needs of the client.
    - E. 3.1.6 Work with team members to assess, plan, and provide an integrated approach to services for clients.
    - E. 3.1.7 Respect team ethics, including confidentiality, resource allocation, and professionalism.
    - E. 3.1.8 Lead the team when appropriate, working collaboratively with team members to deliver client-centred services.
  - E. 3.2 Effectively work with the team to manage and resolve conflict.
    - E. 3.2.1 Respect differences, misunderstandings, and limitations among team members.
    - E. 3.2.2 Recognize own differences, misunderstandings, and limitations that may contribute to team tensions.
    - E. 3.2.3 Manage differences and conflicts to ensure an ongoing team focus on the client’s values, goals, and objectives.
    - E. 3.2.4 Negotiate to resolve conflicts among team members.
    - E. 3.2.5 Demonstrate support for interprofessional team function.
    - E. 3.2.6 Chair or participate effectively in team meetings.

#### **E. 4 “Competent” Practice Manager**

- E. 4.1 Manage day-to-day professional practice and career.
  - E. 4.1.1 Effectively and appropriately prioritize professional duties, including when faced with multiple clients and competing needs.
  - E. 4.1.2 Allocate therapy services while balancing client needs and available resources.
  - E. 4.1.3 Balance work priorities and manage time with respect to client services and practice requirements.
  - E. 4.1.4 Balance work activities, outside activities, and personal priorities.
  
- E. 4.2 Participate in activities that contribute to the effectiveness of the organizations and systems.
  - E. 4.2.1 Participate in systemic quality process evaluation and improvement such as client safety initiatives.
  - E. 4.2.2 Participate in established organizational processes such as workload measurement.
  - E. 4.2.3 Participate in established human resources activities such as annual performance reviews.
  - E. 4.2.4 Participate in established financial and physical resource planning activities.
  - E. 4.2.5 Chair or participate effectively in committees and meetings.
  
- E. 4.3 Supervise support personnel in occupational therapy.
  - E. 4.3.1 Orient support personnel to their role, duties, and responsibilities.
  - E. 4.3.2 Enable the effectiveness of support personnel through mentoring, coaching, and training.
  - E. 4.3.3 Develop a detailed understanding of the competencies of support personnel on the intraprofessional team.
  - E. 4.3.4 Assign appropriate work activities to support personnel working on the team.
  - E. 4.3.5 Comply with provincial regulatory and organizational document standards that apply to working with support personnel in occupational therapy.
  
- E. 4.4 Support fieldwork education.
  - E. 4.4.1 Develop educational activities appropriate to learning objectives and learner needs.
  - E. 4.4.2 Supervise learners in fieldwork education.
  - E. 4.4.3 Provide regular, constructive feedback of the learner’s performance.
  - E. 4.4.4 Evaluate learners using required evaluation forms.
  - E. 4.4.5 Document learner fieldwork and assessment.
  - E. 4.4.6 Comply with provincial regulatory and organizational document standards that apply to fieldwork education.

**E. 5 “Competent” Change Agent**

- E. 5.1 Advocate for the occupational potential, occupational performance, and occupational engagement of clients.
  - E. 5.1.1 Assist the client in obtaining funding and services, as necessary and appropriate, so as to achieve outcomes identified in the action plan.
  - E. 5.1.2 Advocate for occupation and/or occupational performance opportunities for clients.
  - E. 5.1.3 Balance the ethical and professional issues inherent in client advocacy, including altruism, autonomy, integrity, social justice, and idealism.
  - E. 5.1.4 Manage the conflict inherent between the advocacy role for a client and the manager of finite services and resources.
  - E. 5.1.5 Act on identified opportunities for occupation and occupational performance including advocacy, promotion, and prevention with individuals for whom occupational therapy services are provided.
  
- E. 5.2 Advocate for occupational needs related to the determinants of health, well-being, and equity for clients served.
  - E. 5.2.1 Identify the determinants of health of the clients served, including barriers to access services and resources.
  - E. 5.2.2 Identify vulnerable or marginalized clients among those served.
  - E. 5.2.3 Advocate appropriately for the vulnerable or marginalized clients to enable participation through occupation.
  
- E. 5.3 Communicate the role and benefits of occupational therapy.
  - E. 5.3.1 Advocate appropriately for the role of occupational therapy to clients and the interprofessional team.
  - E. 5.3.2 Act on identified opportunities to communicate the role and benefits of occupational therapy in occupational performance and occupational engagement.

**E. 6 “Competent” Scholarly Practitioner**

- E. 6.1 Maintain and enhance personal competence through ongoing learning.
  - E. 6.1.1 Conduct a regular assessment of personal learning needs.
  - E. 6.1.2 Demonstrate lifelong learning skills and document a personal program to keep up-to-date and enhance areas of professional competence.
  - E. 6.1.3 Regularly review new knowledge and determine applicability to practice.
  - E. 6.1.4 Integrate new learning and evidence into practice.
  - E. 6.1.5 Evaluate the impact of any change in practice.
  
- E. 6.2 Critically evaluate information to support client, service, and practice decisions.
  - E. 6.2.1 Critically appraise best evidence in order to address client, service, or practice questions.

E. 6.2.2 Integrate critical appraisal conclusions into daily practice.

E. 6.3 Facilitate the learning of clients, the team, and others.

E. 6.3.1 Identify the learning needs and desired learning outcomes of learners.

E. 6.3.2 Educate about the holistic occupational therapy approach, which incorporates occupational demands, and personal and environmental factors.

E. 6.3.3 Demonstrate effective teaching and assessment approaches.

## **E. 7 “Competent” Professional**

E. 7.1 Demonstrate ethical practice.

E. 7.1.1 Demonstrate appropriate professional behaviours, including honesty, integrity, commitment, compassion, respect, and altruism.

E. 7.1.2 Communicate title and credentials accurately.

E. 7.1.3 Comply with codes of ethics.

E. 7.1.4 Recognize and appropriately respond to ethical issues encountered in practice.

E. 7.1.5 Comply with client confidentiality, privacy practice standards, and legal requirements.

E. 7.1.6 Maintain appropriate relationships and boundaries with clients.

E. 7.1.7 Recognize and respond appropriately to others’ unprofessional behaviors in practice.

E. 7.2 Demonstrate commitment to competent practice.

E. 7.2.1 Actively participate in profession-led regulation.

E. 7.2.2 Comply with professional and regulatory practice standards.

E. 7.2.3 Demonstrate a commitment to competent occupational therapy practice.

E. 7.2.4 Maintain personal competence.

E. 7.3 Display awareness of diversity and the power issues involved in a professional relationship.

E. 7.3.1 Demonstrate awareness of professional privilege and sensitivity to client issues related to professional privilege and client power.

E. 7.3.2 Respect diversity, including but not limited to, the impact of age, gender, religion, sexual orientation, ethnicity, cultural beliefs, and ability on participation and shared decision-making.

E. 7.3.3 Attend to diversity in providing services with respect to client’s needs, values, and goals.

E. 7.4 Contribute to the occupational therapy profession.

E. 7.4.1 Demonstrate behaviours which contribute to the profession, including participation in professional organizations.

## E. 8 Knowledge of Self and Others

An eighth competency, “Knowledge of Self and Others” has been added. Although knowledge of self and others is implicit in the 2007 Profile, the School of Occupational Therapy at The University of Western Ontario believes that this eighth competency should be made explicit. Knowledge of self and others includes the ability to:

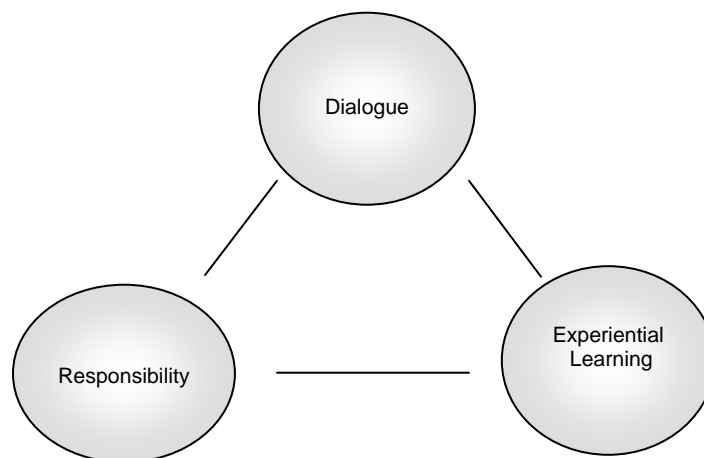
- E. 8.1 Demonstrate knowledge of personal values and assumptions.
- E. 8.2 Regularly reflect on the self in relationship to practice.
- E. 8.3 Demonstrate therapeutic awareness in interactions with clients.
- E. 8.4 Intentionally interact with clients in a way that establishes and maintains a therapeutic relationship (Taylor, 2008).

This eighth competency is congruent with the educational conceptual framework that underlies the present curriculum, as supported by recent literature (Kinsella & Whiteford, 2009; Molke & Laliberte Rudman, 2008; Taylor, 2008) which is more fully discussed below.

## Educational Conceptual Framework

The educational philosophy in this curriculum rests upon a Bakhtinian<sup>3</sup> philosophy that values social responsibility to the “self “ and the “other” through an ethic of dialogue and responsibility (Chornet Roses et al., n.d.), together with the view that experiential learning incorporating reflection is essential for students to internalize such an ethic (Delany & Watkin, 2008; Elliot, 2008; Fowler, 2008). The notions of dialogue and responsibility and an emphasis on experiential learning guide the implementation of teaching and learning approaches that accompany this curriculum into the classroom, clinical placements, and beyond.

**Figure 4. Educational Conceptual Framework**



<sup>3</sup> Mikhail Bakhtin was a philosopher concerned with the relationship between self and others. He believed every person is inescapably influenced by others with whom he or she interacts.

Given this framework, the approach to teaching is “learner-centred”, where in learning is facilitated by engaging learners in understanding, enacting critical thinking, and integrating theory into practice. A *learner-centred* approach is underscored by shared responsibility, where faculty members are responsible to present rich learning opportunities and students are responsible to take advantage of the opportunities and monitor their own learning. A hallmark of this type of environment is a climate of respect and autonomy for students that is envisioned to model and transfer into respect and autonomy for educators (Sackett et al., 2000).

## **Dialogue**

Dialogue consists of verbal, non-verbal, and written communication, social interaction, and professional interaction during clinical fieldwork. These parameters are more fully described as follows:

### **1. Communication.**

Students in occupational therapy must learn to apply different styles of communication in varying contexts, including communication with clients, families, and agencies. Such styles involve negotiating, mediating, and partnering and by, their very nature, demonstrate awareness of and respect for clients in different environments and circumstances. Chornet Roses et al. (n.d.) point out that students must learn “to understand the importance of the impact [they] have on others...it is not simply about *what* they learn but also about the fact that they *are*, and [that] they *are in relation to others*” (p. 7). Chornet Roses et al. point out that, as a consequence, it is important to teach metacognitive skills to students so that they understand not only the content of what they learn, but also who they are in relation to that content and how that content, in turn, relates to others. Communication of curricular content, therefore, is meant to occur in a manner that develops metacognitive skills and communication strategies through reflection, self-appraisal, and action (Georghiades, 2004). In the communication domain, these skills will include developing self-awareness about communication styles and abilities, verbally and non-verbally; presentation skills; and writing skills for conceptual, research, and practice domains.

### **2. Social Interaction.**

Occupational therapy students must learn to work and interact effectively and empathetically with others. As a result, elements of the curriculum are designed to encourage students to work within social contexts and to reflect on the nature and outcome of those interactions. Delivery of curricular content affords students a variety of opportunities to engage in collaborative peer-based teamwork, to learn through engagement in real health contexts, and/or to engage with invited experts who are either consumers or purveyors of health services.

### **3. Professional Interaction.**

Students in occupational therapy are engaging in a transition from the role of student to the role of professional. Elements of the curriculum, therefore, foster and nurture this change in *being* through a variety of approaches, including modeling, didactic teaching of professional

values and standards, professional experiences in context with opportunities for practice, and learning by cases, among others. Each class of occupational therapy students will create a set of values underpinning professionalism in the classroom using CLEAR. CLEAR is a set of values and missions developed by the Faculty of Health Sciences to guide and inspire the Faculty throughout the current strategic plan and beyond. The elements of CLEAR are:

- (1) Community, fostered through planned activities that ensure mutual understanding, mutual meaning, and mutual respect
- (2) Leadership, developed by being positive, honest, supportive and utilizing good communication, recognition, and a team approach
- (3) Expectations, where students and faculty can expect to be treated fairly, to have a voice, and to have their contribution appreciated; in turn each member will perform to meet the expectations of their role
- (4) Appreciation, whereby students and faculty will be appreciated for their accomplishments and, in turn will, appreciate the accomplishments of others, as well as the benefits of being in this environment
- (5) Respect for individuals, which forms the foundation of a positive culture that increases respect, welcomes diversity, and allows all voices to be heard and considered.

## **Responsibility**

Responsibility is enacted through ethical and moral reasoning, individual responsibility, social responsibility to self and others, and learning habits of the mind (Chornet Roses et al., n.d.). These parameters are more fully described as follows:

### **1. Ethical and Moral Reasoning.**

The complexity of practice demands an ability to engage in sophisticated and principled ethical and moral reasoning. Teaching and learning experiences will, therefore, enable students to develop an understanding of their own values and beliefs, informed by an awareness of prevailing occupational therapy values of social justice. The curriculum will support students in assuming responsibility for ethical decision making using a variety of approaches, including learning through cases, learning in context, reflection in action, and artistic expression, among others.

### **2. Individual Responsibility.**

The modern practitioner must be a lifelong learner, able to take responsibility for strategies to synthesize knowledge and transfer that knowledge into change in practice. In addition, self-management and discipline are essential elements in order to balance competing time and resource needs of self and others. A variety of teaching approaches and learning experiences will assist students in enacting individual responsibility for learning, including the management of ongoing, daily demands of course work, learning in clinical contexts, and enacting collaborative teamwork, among others (Anderson & Krathwohl, 2001; Bransford, Brown, & Cocking, 2000; Knowles, 1975; Pintrich, 2004).

### **3. Social Responsibility to Self and the Other.**

The ability to explore, understand, respond to, and facilitate a problem-solving approach for the needs of self and others (clients as well as co-learners) is an essential element of occupational therapy professionalism. Students will engage in a variety of processes through which they will develop an awareness of and sensitivity to social-cultural-institutional environmental contexts from both contemporary and historical perspectives. The intent is to develop practitioners with a proactive sense of responsibility for making just individual, civic, professional, and societal choices.

### **4. Learning Habits of the Mind.**

A variety of teaching approaches will be used that foster the development of students as learners whose curiosity and work ethic create a propensity to explore, critically analyze, reflect upon, and translate evidence into action that enhances practice. Students will also be encouraged to provide constructive feedback to peers and faculty, as well as to deal positively and effectively with feedback, personal and peer setbacks, failures, and/or successes (Pintrich, 2004; Vermunt, 1996; Wolters, 1998).

### **Experiential Learning**

Experiential learning, learning through experience or “doing” is particularly suitable for professional programs, because what is learned must be enacted once in practice. Experiential learning within this curriculum encompasses on-site learning, enabling skills, and fieldwork. These parameters are more fully described as follows:

#### **1. On-site Learning.**

On-site experiential learning within the academic setting can take a multiplicity of formats including, among others, interaction with real and simulated clients, field trips, client and clinical experts in the classroom, case-based learning, practice simulation/clinical labs, workshops, modular learning activities, and use of technology.

Professional education is seen as being in an integral partnership between academic on-site and off-site fieldwork learning. This curriculum recognizes and acknowledges that there is always some tension between the academic and the clinical setting with respect to the teaching role of faculty and that of clinicians. This is particularly true in the current health environment, in which change occurs rapidly and continuously and in which demands often exceed resources. Successful partnering, therefore, requires creativity and close cooperation, which the School of Occupational Therapy at The University of Western Ontario manages by ongoing liaison with individual clinicians and by engaging practicing clinicians on various academic committees, including the MSc(OT) Program Committee, which is charged with overseeing the curriculum.

## **2. Enabling Skills.**

The ultimate goal of this curriculum is to graduate practitioners who are competent to enable occupation using the skills of adapting, advocating, coaching, collaborating, consulting, coordinating, designing and building, educating, and engaging, as described in the Canadian Model of Client-Centred Enablement (CMCE) (Townsend & Polatajko, 2007). Graduates will have achieved the competencies (CAOT, 2007) at the level of at least an advanced beginner, the level at which most new graduates operate as they enter practice (Benner, 1982).

The intent of the experiential element of the educational philosophy is, therefore, to ensure that students who complete this program have the knowledge to competently describe what needs to be done and the skill to enact the competencies necessary for enabling occupation. Thus, students will be required to demonstrate professional competency through the use of various educational and evaluative approaches including, among others, hands-on practice, effective verbal and written communication, teaching ability, ability to work effectively in teams, leadership ability, and planning and organizational ability.

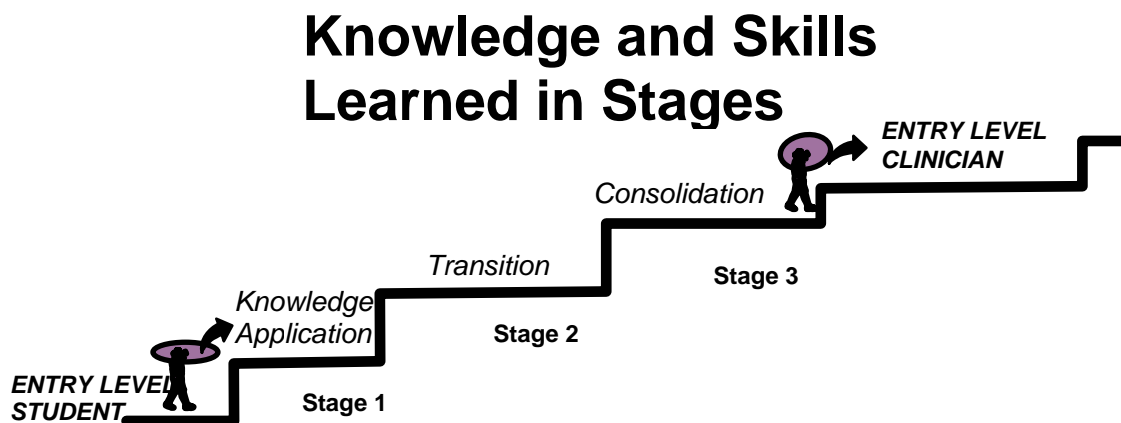
## **3. Fieldwork.**

Students in this curriculum will be engaged in learning in context through hands-on experiences in the class, in the clinic, and in the community. Students will be encouraged and expected to take responsibility for learning in action through engagement, reflection, and participation in placements.

Core competencies encompass a set of knowledge, skills, and attitudes, the development of which are enhanced through experiential learning (Delany & Watkin, 2008; Elliot, 2008; Fowler, 2008). Such experiences collectively reflect the philosophical demands and goals of our profession in a way that captures diversity and innovation. Professional competency develops in three stages:

- Stage 1 - Students develop knowledge application under a supervisory or educational approach that emphasizes direct teaching, evaluation, and feedback.
- Stage 2 - Students enter a transitioning phase in which they need to reflect on action supported by a coaching approach.
- Stage 3 - Students progress to reflection in action supported by a consulting/mentoring approach to teaching.

**Figure 5. Stages of Professional Competency Development**



The fieldwork component reflects a philosophy that students learn best when they have the opportunity to rehearse and apply new knowledge and skills and to transfer knowledge and skills into context. This curriculum recognizes that experiential learning can occur in a broad variety of settings and that fieldwork can occur in any arena in which occupational therapy can develop a role.

Fieldwork is recognized as a vital part of the academic process and is structured to be interspersed with academic learning thus, providing students with an opportunity to integrate and apply on-site academic learning within the University setting to clinical and community settings and vice versa.

### **Delivery of Curricular Content**

In keeping with a philosophy of active learning infused with development of student self-awareness, delivery of curricular content will take a variety of forms and styles (Jones, Higgs, de Angelis, & Prideaux, 2001). The intent is to match content delivery as closely as possible both to the competencies that will be developed by students taking the course and to the contexts of practice within which these competencies are utilized. Thus, courses that deliver material that applies across professional practice in a multiplicity of contexts will be delivered by one faculty member using a variety of educational approaches, as deemed appropriate by the faculty member, within the educational philosophy of the curriculum. This does not preclude the use of visiting experts within these courses to enhance the dissemination of up-to-date and relevant knowledge. Other courses, which deliver content that applies more specifically to

particular practice contexts, will be delivered in a modular format. The use of modules embedded within these courses allows for related information to be taught in a cohesive manner to promote student engagement with the material and to enhance its assimilation. The overarching goal is to use a pragmatic, reflexive approach to curricular delivery, based on the realities of practice in the Canadian context, that is designed to facilitate student learning while making the best use of available resources. The evidence comparing the use of topic-specific modules to an approach in which information is offered across a program is sparse (Parry & Brown, 2009), thus a pragmatic curricular approach in which both are used in order to maximize knowledge integration and transfer appears to be supported by current best evidence (Parry & Brown; Trigwell, Martin, Benjamin, & Prosser, 2000).

Finally, the overarching goal of this curriculum is to graduate occupational therapy practitioners at the advanced beginner/practice entry level as described earlier in this document in all of the “Competent” domains in the CAOT Profile of Occupational Therapy in Canada as well as our eighth competency - Knowledge of self and others. This should ensure that graduates of this program are well-prepared to enter practice.

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