



The Internet Journal of Allied Health Sciences and Practice

<http://ijahsp.nova.edu>

A Peer Reviewed Publication of the College of Allied Health & Nursing at Nova Southeastern University

Dedicated to allied health professional practice and education

<http://ijahsp.nova.edu> Vol. 6 No. 1 ISSN 1540-580X

The Acquisition of Instructional Strategies through a Four-Session Athletic Trainer Clinical Instructor Workshop

Pradeep R. Vanguri, PhD, ATC¹

Jeff Konin, PhD, ATC, PT²

1. Assistant Professor, Clinical Coordinator, Athletic Training Education Program, Department of Orthopaedics and Sports Medicine, University of South Florida
2. Associate Professor, Athletic Training Education Program, Executive Director - Sports Medicine & Athletic Related Trauma (SMART) Institute, Department of Orthopaedics & Sports Medicine, College of Medicine, University of South Florida

CITATION: Vanguri, P., Konin, J. The Acquisition of Instructional Strategies through a Four-Session Athletic Trainer Clinical Instructor Workshop. *The Internet Journal of Allied Health Sciences and Practice*. Jan 2008, Volume 6 Number 1.

ABSTRACT

Athletic training clinical education combines didactic education with practical experiences. Athletic training education programs facilitate the development of this instruction by preparing the clinical instructors affiliated with the program. Primarily through one-time workshops, this effort provides limited delivery of content to prepare these clinical instructors. In an attempt to identify which method of content delivery would most benefit clinical instructors, this research creates a unique methods to further investigate this issue. This study compared the acquisition of knowledge between the traditional single session clinical instructor workshop to a modified four-session workshop on athletic training clinical education instructional strategies. **Method:** A pre-post assessment was utilized to measure the acquisition of clinical instruction skills for a control and experimental group of clinical instructors within a single accredited athletic training education program. Eleven clinical instructors participated in the experimental group while fifteen clinical instructors participated in the control group (N=26). A standardized instrument for assessment compared control and experimental group participants' acquisition of information delivered through the clinical workshop models. **Results:** Statistical analysis of the results from the testing instrument identified a statistical difference ($p=.003$) between the control and experimental groups implying an acquisition of knowledge from the clinical instructor workshop interventions. **Conclusions:** This study supports the implementation of multiple session clinical workshops for athletic training clinical instructor workshop training as an alternative method to the traditional single session workshop delivery mode. Nurturing clinical instructors through instructional develops a positive learning environment to ensure their success.

INTRODUCTION

Clinical instruction connects the classroom to the practical experiences via mentors that guide athletic training students through daily interaction, providing direction and feedback on an ongoing basis while providing comprehensive patient care. Athletic training clinical instructors are employed in a variety of settings, including but not limited to secondary schools, colleges and universities, professional teams, rehabilitation clinics, and other unique environments. Though formal preparation of clinical instructors occurs within the established guidelines of an accredited athletic training education program, clinical instructors often bring a set of individualized skills set, philosophy, and teaching style to the clinical setting. A majority of the responsibility to educate students in the clinical setting is based upon the ability of the clinical instructor to understand the learning styles of a student, appropriate instructional strategies to support the educational experience, and guidelines to develop effective modeling of the clinical instructors.^{1,2} Educating clinical instructors to understand instructional methods promoted by athletic training education programs reinforces the growth of positive mentoring and consistency within a system. This instructional development is often incorporated through the clinical instructor workshops required by accreditation standards and guidelines set forth for

athletic training education programs.^{3,4} These workshops also allow for opportunities to discuss the comparisons of techniques found amongst clinical instructors used to mentor students.^{1,5,6} Similar to commonly held faculty development efforts, previous studies have reported that one-time workshops do not effectively assist in the acquisition of instructional behaviors amongst participants.^{7,8}

Little research compares a one-time workshop to a multiple-session workshop in which both models deliver the same content. Multiple workshop sessions that expand beyond a single day may allow additional time and practice of instructional strategies combined with peer-to-peer interaction between sessions. Additionally, adult learners benefit most from receiving instructional strategies and techniques specific to their needs, such as time to assimilate and place into action newly learned skills.^{9,10,11,12} Kolb's work on learning styles and the experiential learning cycle provides a theoretical framework for a multi-session clinical instructor workshop.¹³ Through Kolb's Learning Style Inventory (LSI), based on the ability to identify how a person deals with ideas and day-to-day situations, it is theorized that multi-session clinical educator workshops could allow for inter-session learning acquisition and discussion of ongoing experiences. Kolb's LSI identifies four learning styles: converger, diverger, assimilator, and accommodator, and explores how these learning styles and modes effect each individual, in addition to the various stages of the experiential learning cycle.^{14,15} Harrelson and colleagues investigated the learning styles of athletic training educators who attended the 1999 National Athletic Trainers' Association Educators' Conference and reported that 76% of the athletic training educators who attended the conference were convergers or assimilators, while athletic training students reveal an equal distribution of learning styles.^{16,17} Because a correlation between teaching and learning styles contribute to the acquisition of student knowledge, better understanding of this relationship as it pertains to clinical instruction may improve instructional methods.¹

Sharing information with clinical instructors regarding characteristics that athletic training students find helpful during their clinical experiences should be a vital component of a clinical educator workshop. Laurent and Weidner compared student and clinical instructor perceptions, documenting over 200 athletic training students' and 40 clinical instructors' rankings of what they described as the least and most helpful characteristics possessed by a clinical instructor.¹⁸ Among the most helpful characteristics identified were displays confidence, respect for the student, manages clinical emergencies well, provides opportunities for students to practice, and demonstrates skills for the student.¹⁸ Weidner and Henning also addressed the issues of clinical instruction by identifying nine categories of characteristics to develop effective clinical instruction. These included legal and ethical behavior, communication, interpersonal, supervision, instruction, evaluation and assessment, clinical competence, administrative, and professional development.¹⁹ These studies identify some specific characteristics used to develop effective clinical instruction, but do not include specific recommendations on the method and timeframe best integrated for developing these attributes. The purpose of this study was to compare the learning acquisition of athletic training clinical instructors between a one-time versus a multiple-session clinical education workshop.

METHODS

A convenient sample of 30 clinical instructors affiliated with an accredited undergraduate athletic training education program served as subjects, although this may have contributed to a weakness of the study. Fifteen clinical instructors were assigned to the control group, each of whom were located at an off-campus clinical education site (secondary school, small college, private practice clinical setting). The remaining fifteen clinical instructors comprised the experimental group, each of whom were located at the host educational institution in a large university athletic department setting. The average number of years of experience as a certified athletic trainer was 11.3 and 5.2 for the control and experimental groups, respectfully.

The control and experiment group participated in a clinical instructor workshop held over the course of a four-hour timeframe at the beginning of the academic year in the fall. However, the experimental group received additional workshop content and instruction related to athletic training clinical education in the form of additional workshop sessions. These experimental participants received formal instruction on time management strategies, Kolb's learning styles, instructional strategies, and communication skills. Sessions for the experimental group were held in consecutive weeks throughout the first 2 months of a spring academic semester, a full semester following the original workshop. Prior to the spring semester, a memorandum outlining the dates, times, and extent of this research study was sent to each clinical instructor for informational purposes and agreement to participate. Incentives for each session included continuing education units for each hour of attendance and a stipend upon completion of all four sessions. Sessions were divided by content: time management, learning styles, instructional strategies, and communication (Table 1). The Institutional Review Board for the Protection of Human Subjects at the host institution approved this study.

Table 1. Intervention Techniques

Intervention	Techniques
Time Management	Outlining semester, month, and week for athletic training students. Establishing dates for assignments, tests, practices and games. Independent activity for CI to identify schedules. Discussion of policies and procedures for any violation of these times for athletic training students.
Learning and Teaching Style	Completion of Kolb's LSI. Explanation and discussion of results from LSI. Small group activity to demonstrate learning and teaching styles using results from LSI. Discussion of learning styles.
Instructional Strategies	Demonstration of clinical proficiency and scenario assessment. Demonstration of appropriate and inappropriate teaching behaviors. Activity with pairs to complete clinical proficiency and scenario assessment. Discussion of various instructional strategies implemented.
Communication	Role play of various scenarios in clinical setting with clinical instructors, student-athletes, and athletic training students. Discussion of positive and negative aspects of the role play, as well as any additional solutions to each scenario.

The quantitative instrument was administered one week prior to and one week following the additional clinical instructor workshop to both control and experimental groups (Appendix A). Demographic data on this instrument for the clinical instructor included clinical site, years of experience, and level of education. These four items were open-ended statements at the top of the first page of the instrument, following the cover page.

The first section of the clinical instructor instrument was developed to specifically assess the content covered in the experimental clinical instructor workshop. Eighteen multiple choice questions were developed to assess the areas of time management (4 questions), learning styles (4 questions), instructional strategies (4 questions), and communication (6 questions). Although there were two more questions for the communication section, this instrument included a generally equal distribution of questions from each of the content areas. Each multiple-choice question included four possible responses, of which only one was the correct response. Incorporating specific concepts from the sessions, this assessment provided insight into the acquisition of knowledge from the clinical instructor workshop.

The second section of the clinical instructor instrument included fifteen Likert-type statements on the areas of time management (6 statements), learning styles (2 statements), instructional strategies (4 statements), and communication (3 statements). In order to assess user attitudes towards the content areas addressed in the clinical instructor workshop, a Likert-type attitude scale was constructed in which the respondents were presented with a statement and selected the degree to which they agreed or disagreed with the statement.²⁰ For this instrument, the statements included a five-point scale from 1 to 5, where 1= strongly disagree, 2= disagree, 3= moderate, 4= agree, and 5= strongly agree. These statements were intended to measure any change in attitudes for the participants on the content areas addressed in the clinical instructor workshop.

Content validity of this instrument was established by including five athletic training educators during the design. These athletic training educators, including faculty members and doctoral students, reviewed each item by completing the instrument as if they were participating in the study to reveal any areas in need of clarification. In addition, they were able to provide some additional insight into the perspective of the clinical instructor who may have been exposed to these instructional strategies. The pretest was conducted prior to the first session with both the control and experimental groups. This pretest was administered to the experimental group as a whole prior to the first session. For the control group, the pretest was administered individually at their clinical site or office. These documents were collected immediately for the experimental group, while the control group was given a day to complete the assessment. Upon completion of the pretest evaluation conducted by the clinical instructor, the experimental group participated in the first intervention, while the control group received no additional interactions. Upon completion of the fourth intervention, both groups completed the posttest evaluation.

Pre and post data from the clinical instructor instrument including control and experimental groups were coded and analyzed. Data from both control and experimental groups were separated into pre- and post-intervention data. For the multiple-choice

items, the number of correct responses was tabulated for each subject's pre- and posttests in both groups. Items from the Likert-type scale included responses of "Poor" to "Excellent," and were recorded on a numerical scale from 1 to 5 for all 15 items. As this portion of the instrument was divided into four categories that corresponded with the interventions, these four categories were totaled by the number of items per section: 6 time management statements, 2 learning style statements, 4 instructional strategy statements, 3 communication skill statements. This allowed a more precise examination of the attitudes toward each specific intervention in the workshop. The total number of correct responses for the multiple choice section and scores from each section of the Likert-type section were recorded for each subject within both control and experimental groups, pre- and post-interventions.

Statistical significance in pre- and post-data from group data was noted on the total number of correct scores for the multiple choice section between both the control and experimental groups. Pre- and post-data for the control and experimental groups were analyzed for statistical significance using an analysis of covariance (ANCOVA).^{20,21} In this analysis, pre-data were used as the covariate, post-data were used as the dependent variable, and the group was the independent variable. Then, an ANCOVA was conducted to determine any statistical significance between section scores of the control and experimental groups, pre and post on the Likert-type statements.^{20,21} In this analysis, pre-data from all four sections were used as the covariate, post-data from all four sections were used as the dependent variable, and the group was the independent variable. In addition, scores from the Likert-type statements were also analyzed using an analysis of variance (ANOVA). The difference between the pre- and post-scores from each section were used as the dependent variables and the group was the independent variable.

RESULTS

Through an analysis of covariance (ANCOVA), statistical significance was determined between the control and experimental groups and their performance on the clinical instructor instrument. A covariate is defined as a source of variation not controlled for in the design of the experiment, but that the researcher believes to affect the dependent variable.²² The covariate is used to statistically adjust the dependent variable in any research that includes a comparison of scores from a pre- and posttest. As this project incorporated a quasi-experimental design, the ANCOVA model accounts for situations where there are intact groups and the researcher is not able to randomize the groups for a true experimental design.²² Since this project utilized two intact groups of on-campus and off-campus clinical instructor, the ANCOVA model reduced the amount of variation and the greater the linear relationship between the covariate and the dependent variable, the greater the amount of uncontrolled variation that can be removed from the analysis. Thus, the use of a covariate yields a more precise and less biased estimate of the group effects. Demographic data from these two groups revealed a heterogeneous sample of certified athletic trainers (Table 2).

Table 2. Demographics for Control and Experiment Groups (n=26)

Group	Control	Experiment
Male	8	2
Female	7	9
College	1	11
Clinic	5	0
HS	9	0
Masters Degree	7	4
Bachelors Only	7	8
Average Yrs of Experience	5.2	11.3
TOTAL	15	11

The assumptions of the ANCOVA model include the covariate being measured without error, homogeneity of the regression slope, and independence of the independent variable.²² One of the main assumptions of the ANCOVA model included assessing the slopes of both control and experimental groups. An analysis of both slopes was evaluated prior to using the ANCOVA, and was revealed to be of some statistical interest ($p=.053$, alpha level=.05). Although this measurement was slightly above the alpha level, it prompted a more in-depth analysis of the data using the ANCOVA model. This research project compared the total number of multiple choice questions answered correctly out of the 18 possible items for both control and experimental groups. Twenty-six participants ($n=26$) completed the pre- and posttest assessment for this research project with 15 from the control group and 11 from the experimental group. The pre-test and post-test mean values for the number of multiple choice items answered correctly for both groups was used in the ANCOVA. Of the 18 items in this section, the experimental group mean (14.27) was higher than the control group mean (11.13) on the posttest assessment (Table 3). The standard deviation for the control group was 2.53, while the standard deviation from the experimental group was 2.76, indicating a slight variance in the experimental scores compared to the control group. Using this information, the post-test means for the multiple choice sections

were used as the dependent variable in the ANCOVA. The pretest scores on the multiple choice items were the covariate for the analysis of covariance.

Table 3. Descriptive Statistics for Multiple Choice Sections

Group	Pre-Mean	Post-Mean	Standard Deviation	N
Control	10.47	11.13	2.53	15
Experiment	9.38	14.27	2.76	11
Total	9.96	1.46	3.02	26

The ANCOVA summary table identifies the covariate, adjusted means between groups, adjusted means within groups, the corrected total, and the degrees of freedom (df) (Table 4). From this information the mean square (MS), F-statistic (F), and the statistical significance were also calculated. Results from the multiple choice section indicated a statistical significance between the control and experimental groups ($p=.003$, alpha level=.05). In addition, the level of power from this analysis indicated a strong statistical significance (power=.888). Based on these findings, mean test scores between the control and experimental group were statistically significant, pre and post. This statistically significant difference between control and experimental groups implies an acquisition of knowledge from the clinical instructor workshop interventions.

Table 4. Analysis of Covariance Summary Table for Multiple-Choice Section

Source	SS	df	MS	F	Sig.	Partial Eta Sq	Power
Covariate	15.03	1	15.03	2.29	.144	.091	.306
Group	72.22	1	72.22	11.01	.003	.324	.888
Error	150.89	23	6.56				
Corrected Total	228.46	25					

Results from the Likert section were analyzed based on the four separate sections of time management, learning styles, instructional strategies, and communication skills. Each section was analyzed separately to investigate any statistically significant findings from a specific content area. An attempt was made to use an ANCOVA approach similar to the multiple choice section. For all four sections of the Likert statements, the mean score for both control and experimental groups was calculated pre and post. Prior to the ANCOVA, an assessment of the slopes was conducted to determine if the data met this assumption. As the results of this assessment did not yield a favorable result for the slopes of both groups, an ANCOVA procedure was not utilized for this section. It was assumed that the results from the specific area of the Likert section would yield similar results from the other areas of learning styles, instructional strategies, and communication skills. Therefore an ANOVA was used to determine if there was a statistical significance between the means for each section of the Likert questions. Although these data did not indicate any statistical significance between control and experimental groups for any section of the Likert items, future inquiries into attitude assessment may yield significant results. The limited time of five weeks from pretest to posttest may have limited a true assessment of attitudes from this research.

DISCUSSION

The purpose of this study was to compare the acquisition of learning for athletic training clinical instructors when participating in a single session versus a multiple session clinical educator workshop. Results from this study showed an increase in the acquisition of general knowledge pertaining to instructional strategies. As evidenced by the results of the testing instrument, learning may occur over a period of time through the teaching of various techniques regardless of the platform utilized to teach the content.^{22,23} The amount of time for each of the experimental sessions was limited to 1½ hours. Although there was sufficient time for the instruction of the four content areas, future research incorporating a clinical instructor workshop may benefit from increased time for each session to allow for greater depth of the content.

Using an ANCOVA analysis, the posttest scorers from both groups were statistically significant between control and experimental groups, implying an acquisition of knowledge from the clinical instructor workshop interventions. This exploratory research implemented a unique workshop format to provide consistent interactions allowing increased time with the content. Although the control group received the same instrument pre and post, this did not increase their knowledge or awareness of instructional strategies. The statistical significance between groups on the multiple choice items may also indicate the workshop format and number of interventions assisted in the acquisition of knowledge.^{22,23} In addition to the format of the workshop, the type of activities implemented in each session incorporated instructional strategies to accommodate for the learning styles of the participants in the workshop.^{8,23} Although these data revealed a statistical significance, the results were only generalizable to the

population of the 26 clinical instructors affiliated with the institution used in the study. Future investigations of this workshop format may include additional clinical instructors or institutions to generalize results to a broader population of clinical instructors.

The next section of the clinical instructor instrument utilized Likert-type items to investigate any difference in attitude between control and experimental groups. This section of the instrument was divided into the four sub-sections of time management, learning styles, instructional strategies, and communication. Analysis of the results from all four sub-sections did not yield any statistical significance between both groups despite yielding a high reliability. Although these data did not indicate any statistical significance between control and experimental groups for any section of the Likert-type items, future inquiries into attitude assessment may yield significant results. The limited time of five weeks from pretest to posttest may have limited a true assessment of attitudes from this research. A longer time-lapse from pre- to posttest assessment may yield more favorable results on Likert-type items providing additional insight into the workshop format.

Of significance to note, the influence of Kolb's LSI on the participants in the experimental group impacted the discussions throughout the sessions. The focus of this session was to allow for each participant to complete the LSI to identify their own personal learning style as well as the instructional strategies to accommodate their learning. Some of the participants had previously been exposed to Kolb's LSI, and thus this process served as a reminder of their learning style. These individuals could not have been exempted from the study, however, since they were part of the convenience sample, and not including them in the statistical analysis would have decreased the overall power of analysis.

The activities implemented in each session incorporated a variety of instructional strategies to accommodate learning styles of the specific participants in the workshop.^{23,24} Future workshops, however, may implement a longer time-lapse between test assessments to yield more significant findings on Likert-type items which would further assess acquisition of learning for those who have previous experience either as a clinical instructor or with the learning style inventory assessment. Harrelson et al. and Gardner and Harrelson identified the significance of understanding differences in learning styles from the perspective of the clinical instructor and student.^{1,16} Developing this understanding promotes the awareness of the clinical instructor to both his personal learning style and that of the athletic training student. Despite the intent to standardize the lesson plan, it is also critical to modify the plan slightly to meet the needs of the participants' level of knowledge and learning style. A session on instructional strategies further promoted learning styles with the athletic training clinical proficiencies and clinical scenarios.

CONCLUSIONS

Contrary to a one-time intervention, a multi-session format such as the one described in this study can lend itself to greater acquisition of clinical education teaching skills as well as individual program objectives and guidelines. Scheduled shorter lengths of workshops may also be more appealing to individuals as opposed to a single session 4-5 hour program. The risk of such multiple sessions is if individuals are unable to attend one of the sessions, then information may be fragmented and ultimately impact the learning acquisition. This would especially hold true if the sessions were incrementally designed to build upon one another.

Future studies may consider not segregating clinical instructors by their on- versus off-campus locations. Groups were selected in this manner to reduce interaction amongst clinical instructors based upon clinical site location in an effort to reduce the maturation of participants during the learning process.²⁰ Future studies of this kind may also consider altering the length of total multiple sessions, the length of each session, and the delivery of content over an extended period of time.

This work provides an impetus to consider the development of multiple-session workshops that nurture peer-to-peer interactions and provide unique methods of instruction for all professions versus the standard one-day workshop. As clinical instructors differ in learning styles, accommodating these styles will also require unique approaches to disseminate information. Incentive-based workshops may also serve to facilitate compliance amongst participants.

This study demonstrated an increase in learning acquisition for athletic training clinical instructors when partaking in a multiple session workshop on clinical instruction versus a traditional single session program. Although the workshop developed for this research project involved instructional strategies for athletic training education clinical instructors, using a similar workshop format may benefit clinical instructors and faculty members from other professions. These efforts should continue to incorporate unique methods of instruction and the opportunity to share ideas with peers to create acquisition of instructional strategies. Nurturing clinical instructors through instructional strategies serves to develop a positive learning environment to ensure this success.

REFERENCES

1. Gardner G, Harrelson G. Situational teaching: Meeting the needs of evolving learners. *Athletic Therapy Today*. 2002; 7(5), 18-22.
2. Harrelson G, Leaver-Dunn D. Using the experiential learning cycle in clinical instruction. *Athletic Therapy Today*. 2002; 7(5), 23-27.
3. CAATE. *Standards for accreditation educational program for the athletic trainer*. Chicago, IL: CAATE; 2005.
4. Joint Review Committee–Athletic Training (JRC-AT). Accredited undergraduate athletic training education programs. Available at: <http://www.jrc-at.org/>. Accessed on August 17, 2004.
5. Davis N. Continuing education meetings and workshops: effects on professional practice and health care outcomes. *The Journal of Continuing Education in Health Professions*. 2001; 21, 187-199.
6. Green M., Gross C, Kernan W, Holmboe E. Integrating teaching skills and clinical content in a faculty development workshop. *Innovations in Education and Clinical Practice*. 2003; 18, 468-474.
7. Schuster J. The personal dimension: Faculty development. *Thought & Action*. 1989; 5(1), 61-72.
8. Weimer M, Lenze L *Instructional interventions: A review of the literature on efforts to improve instruction*. *Teaching and Learning in the College Classroom*. Needham Heights, MA: Ginn Press. 1998.
9. Dewey J. *How we think*. Boston, MA: DC Heath. 1933.
10. Knowles, M. Andragogy, not pedagogy. *Adult Leadership*, 1968; 16(10) 350-352, 386.
11. Knowles, M. Innovations in teaching styles and approaches based upon adult learning. *Journal of Education for Social Work*, 1972; 8(2), 32-39.
12. Knowles, M., Holton, E.III, & Swanson, R. *The Adult Learner* (5th ed.). Houston, TX: Gulf Publishing. 1998
13. Kolb D. *The Learning Style Inventory* (Boston, Ma., McBer & Co.). 1971, 1976,1981.
14. Kolb D. *Learning-Style Inventory User's Guide*. Boston: McBer & Company. 1996.
15. Atkinson G. Kolb's learning style inventory: A practitioner's perspective. *Measurement and Evaluation in Counseling and Development*. 1991; 23, 149-161.
16. Harrelson G, Leaver-Dunn D, Martin M. Learning styles of athletic training educators. *Athletic Therapy Today*. (2003). 8(4), 62-64.
17. Stradley S, Buckley B, Kaminski T, Horodyski M, Flemming D, Janelle C. A nationwide learning style assessment of undergraduate athletic training students in CAAHEP-accredited athletic training programs. *Journal of Athletic Training*. 2002; 37(4):S141-S146.
18. Laurent T, Weidner T. Clinical instructors' and student athletic trainers' perceptions of helpful clinical instructor characteristics. *Journal of Athletic Training*. 2001; 36(1), 58-61.
19. Weidner T, Henning J. Being an effective athletic training clinical instructor. *Athletic Therapy Today*. 2002; 7(5), 6-11.
20. Gall MD, Gall JP, Borg WR. *Educational research: An introduction* (7th ed.). New York, NY: Allyn and Bacon. 2003.
21. Lomax, R. *An Introduction for Statistical Concepts for Education and Behavioral Sciences*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc. 2000.
22. Dixon, N. Incorporating learning style into training design. *Training and Development Journal*. 1982; 36(7), 62-64.
23. Stamp N, Pagano A. Evaluation of a workshop series in university science education. *BioScience*. 2002; 52(4), 366-372.
24. Joyce B, Showers B. Student achievement through staff development (3rd ed.). Alexandria, VA: Longman. 2002.

Appendix A – Clinical Instructor Instrument**CLINICAL INSTRUCTOR** _____
HIGHEST DEGREE EARNED _____**CLINICAL SITE** _____
YEARS OF EXPERIENCE _____*Multiple Choice*

1. How many hours a week does an average college student need to sleep?
 - a. 56
 - b. 54
 - c. 49
 - d. 48

2. Given an average student course load of 15 hours of class, how many hours should a college student spend on course work per week?
 - a. 15 hours in class + 30 hours studying=45 hours
 - b. 15 hours in class + 35 hours studying=50 hours
 - c. 15 hours in class + 40 hours studying=55 hours
 - d. 15 hours in class + 45 hours studying=60 hours

3. How many hours does an average adult work in a week?
 - a. 45
 - b. 50
 - c. 55
 - d. 60

4. Given a 168-hour week, time for sleep (56), attending classes (15), studying (30), and eating (21), how much time is left over for fun, relaxation, and recreation?
 - a. 46 hours a week
 - b. 45 hours a week
 - c. 40 hours a week
 - d. 38 hours a week

5. According to Kolb's Learning Style Inventory, which of the following learning styles includes students who are successful on intelligence tests and prefer to deal with things rather than people?
 - a. Converger
 - b. Diverger
 - c. Assimiliator
 - d. Accomodator

6. According to Kolb's Learning Style Inventory, which of the following learning styles includes students who perform better with brainstorming or generating ideas, are interested in people, and tend to be imaginative and emotional?
 - a. Converger
 - b. Diverger
 - c. Assimiliator
 - d. Accomodator

7. According to Kolb's Learning Style Inventory, which of the following learning styles includes students who are less interested in people and more with abstract concepts, and less concerned with practical use of theories?
 - a. Converger
 - b. Diverger
 - c. Assimiliator
 - d. Accomodator

8. According to Kolb's Learning Style Inventory, which of the following learning styles includes students whose greatest interest lies in doing things, carrying out plans and experiments, and are at ease with people?
 - a. Converger
 - b. Diverger
 - c. Assimiliator
 - d. Accomodator

9. The most ideal instructional strategy for a Converger is to
 - a. Incorporate problem solving with technical skills
 - b. Allow them to observe the situation
 - c. Discuss the logical theory involved
 - d. Create a hands-on experience with other people

10. The most ideal instructional strategy for a Diverger is to
 - a. Incorporate problem solving with technical skills
 - b. Allow them to observe the situation
 - c. Discuss the logical theory involved
 - d. Create a hands on experience with other people

11. The most ideal instructional strategy for a Assimilator is to
 - a. Incorporate problem solving with technical skills
 - b. Allow them to observe the situation
 - c. Discuss the logical theory involved
 - d. Create a hands on experience with other people

12. The most ideal instructional strategy for a Accomodator is to
 - a. Incorporate problem solving with technical skills
 - b. Allow them to observe the situation
 - c. Discuss the logical theory involved
 - d. Create a hands on experience with other people

13. When communicating with students, the students should
 - a. Know what you are thinking and feeling
 - b. Be able to predict what you are thinking
 - c. Hear what you are thinking and feeling
 - d. Assume what you will be thinking and feeling

14. In any relationship you should always communicate by
 - a. Dropping hints about your concerns
 - b. Getting right to the point when discussing a concern
 - c. Stating what you don't like
 - d. Withdrawing from a conflict or conversation

15. When in conversation with others
 - a. One person should do most of the talking.
 - b. Allow the person who started the conversation to finish
 - c. Allow the other person to do most of the talking.
 - d. Equalize participation in the conversation.

16. It is important to make eye contact
 - a. A few times while conversing
 - b. Often while conversing
 - c. Sometimes while conversing
 - d. Never while conversing

17. A good listener

- a. Tends to be distracted by things going on around them
- b. Listens for key phrases
- c. Listens for meaning and ask questions
- d. May watch the person speak, but not "hear" a word.

18. When giving feedback for improvement

- a. Focus on the person's observable work or behavior and offer suggestions
- b. Focus on what you don't like about the person
- c. Focus on what you do like about the person
- d. Simply tell the person what to do right

Likert-Type**EVALUATION SCALE:**

1 = Strongly Disagree 2 = Disagree 3 = Moderate 4 = Agree 5 = Strongly Agree

DIRECTIONS: Please use the scale above to evaluate yourself by circling the appropriate number. There are **four sections** that ask you to separately evaluate yourself **as a Clinical Instructor**

Time Management

1. Time management strategies are essential with my clinical responsibilities.	1	2	3	4	5
2. Time management strategies are essential with my athletic training students.	1	2	3	4	5
3. Time management strategies are essential with my personal responsibilities.	1	2	3	4	5
4. Time management strategies are essential with my clinical schedule.	1	2	3	4	5
5. Time management strategies are essential with my athletic training students' schedule.	1	2	3	4	5
6. Time management strategies are essential with my personal schedule.	1	2	3	4	5

Teaching and Learning Styles

7. Teaching and learning styles are essential with my athletic training students.	1	2	3	4	5
8. Teaching and learning styles are essential with other athletic training students.	1	2	3	4	5

Instructional Strategies

9. Instructional strategies are essential with my athletic training students.	1	2	3	4	5
10. Instructional strategies are essential with other athletic training students.	1	2	3	4	5
11. Instructional strategies are essential with clinical proficiency and scenario assessments.	1	2	3	4	5
12. Instructional strategies are essential with teaching behaviors.	1	2	3	4	5

Communication Skills

13. Communication skills are essential with my athletic training students.	1	2	3	4	5
14. Communication skills are essential with other athletic training students.	1	2	3	4	5
15. Communication skills are essential with clinical scenarios in my setting.	1	2	3	4	5