

A CURRICULUM PLAN FOR THE PROFESSIONAL
EDUCATION OF OCCUPATIONAL THERAPISTS IN NIGERIA

FRANCIS OLATOKUNBO OLADOKUN OSIKOYA

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ABSTRACT

This study was concerned with the planning of a curriculum for training occupational therapists in Nigeria. In doing so, both theoretical and practical matters were considered.

First, the thesis identifies the need for occupational therapists in Nigeria, and, based on a literature review, theoretical perspectives and issues about curriculum, and about professional education are gathered and discussed. Secondly, the research for the study was conducted through different practical means. The first part of the research was directed at all the occupational therapists in Nigeria seeking facts and opinions on the occupational therapy situation in the country. A mail questionnaire composed of structured and open-ended questions was used. The second study attempted to find out international perspectives on the training of occupational therapists through a mail questionnaire using open-ended questions, directed at the World Federation of Occupational Therapists, Occupational Therapy Associations in several countries, and all occupational therapy training schools in the United Kingdom. This was followed by a third piece of research in which a case study of the policies and practices of two occupational therapy training programmes in Scotland was carried out, using interviews.

The findings in these investigations and the issues and arguments derived from the literature on curriculum theory and professional education were considered against the background of Nigeria. The discussion was used to develop principles and to suggest a curriculum for the training of occupational therapists in Nigeria.

The study offered some suggestions for future monitoring of the programme and areas of future research in Nigeria.

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When I was offered a scholarship by the Federal Government of Nigeria to do this study, such was my ambivalence that on the one hand I saw the task as close to impossible but at the same time I saw it as an opportunity for me to be involved in creating something new and useful to my country. So, the challenge was accepted.

The creation, development and completion of the work could not have been possible and smooth but for the efforts, encouragement, support and special knowledge of certain individuals. I am very grateful to everyone concerned.

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CHAPTER ONE

INTRODUCTION

The aim of this study is to develop a curriculum plan for the training of occupational therapists in Nigeria.

1.1 The Purposes Behind The Study

There are several reasons why this study has been conducted. A main stimulus has been the efforts of the Federal Government of Nigeria to provide comprehensive health care for Nigerians. An extract from the Guidelines for the 4th National Development Plan, 1981-1985, of the Federal Republic of Nigeria states:

In spite of the importance of health to the welfare of the individual and to socio-economic development of the nation, health services, in all their various facets, have remained inadequate relative to demand from the rapidly growing population. Substantive achievements have been made over the years but existing facilities are still inadequate ... The main objective of policy was to improve and build new ones, to correct the maldistribution of facilities and raise the supply of health manpower.

One of the health care services that can help towards achieving this objective is that of occupational therapy. With a great shortage of occupational therapists in the country, this posed a serious problem which was further compounded by the fact that there is no training programme for occupational therapists in Nigeria. In the past, Nigerian occupational therapists have been trained overseas. But, for many years now, the country's economic situation has not made it possible either for the Government or for private students to embark on undergraduate courses

overseas.

There is a desire by the Federal Government of Nigeria for self-sufficiency in providing occupational therapy personnel in Nigeria.

In the health sector, the Federal Government of Nigeria, in its efforts, is more determined than ever before to train Nigerians to work within Nigeria's social and cultural system and to solve the country's special health problems. The proposal, then, is that a department of occupational therapy be created in the present institution for the training of physiotherapists in Kano.

In 1984, the Federal Government of Nigeria awarded me a post-graduate scholarship (Appendix 1A) and sent me on leave overseas from my post in the occupational therapy service in Nigeria to undertake the study of policies and practices in the professional education of occupational therapists, with the expectation that on my return to Nigeria I would become responsible for the establishment of the first occupational therapy training programme in that country.

This opportunity and responsibility which was given to me I have accepted as a challenge.

As an occupational therapist, I had my initial

professional training in the United Kingdom. My post-initial professional training and graduate work were done in Canada and the United States respectively. Also I have had professional working experience in these countries as well as in Nigeria. While my professional practice overseas has exposed me to a variety of practice situations, it has also exposed me to the opportunity of getting involved in the professional education of occupational therapists and occupational therapy activity instructors in the capacities of Clinical Lecturer, Clinical Consultant and Co-ordinator of Occupational Therapy Activity Instructor Training Programmes. Likewise, my professional education: for example, in the thesis for my Master's degree of the University of Alabama in Birmingham in 1980, I attempted to isolate and define the factors responsible for grade distribution in four basic occupational therapy courses. Therefore, it is important to state here that in addition to the investigations carried out in this study, my report may reflect some aspects of both my own personal professional training and working experiences.

1.2 The Problems In The Study

Having said all that, the study poses problems for me in several senses. Firstly, there are 'problems' in the sense of 'obstacles' or 'difficulties'. There are practical difficulties of planning the curriculum such as the following.

1. There is no existing model in Nigeria or comparable country that one could study or seek advice.
2. There is a desire to develop a model appropriate to Nigeria but at the same time one that is internationally acceptable and acceptable to other medical professions.
3. We are concerned about borrowing ideas which are foreign to Nigeria and which may be incompatible with our needs, culture and educational systems.
4. Most writers of curricula seem to write more about general education rather than professional education.

The second kind of 'problem' in the study concerns the nature of the research problem being investigated. It is a problem in the sense of an interesting puzzle for me to solve by research. This second problem can be defined by the question: How can research help us to analyse and understand the first types of problems? What questions should we try to answer? This causes us to ask the general question: What should be the curriculum for professional education of occupational therapists in Nigeria? This in turn raises a number of subordinate questions in trying to clarify what the various terms mean: for example

What is a 'curriculum'?

What is 'professional education'?

What is 'occupational therapy'?

What is 'Nigeria' i.e. what is special about the country as a context for occupational therapy?

Thus we can develop more detailed questions as follows:

1. What is meant by 'a curriculum'?

What is the scope of curriculum and curriculum planning e.g. does it include teaching, resources, examinations? What general approaches are there to planning curricula? What special requirements are there in a curriculum for professional education?

2. What are the conditions in Nigeria that are relevant to the study?

How is occupational therapy in Nigeria carried out at present?

What are the needs for occupational therapy in Nigeria?

What decisions have already been made?

What models of professional education exist in Nigeria which the occupational therapy programme may have to match?

What are the cultural features of Nigeria that may affect the carrying out of occupational therapy or this training programme?

3. What is occupational therapy?

What is the nature of the work of occupational therapy?

What abilities does it require?

What kind of profession is it? What is it compatible with?

How is this reflected in the curriculum for training in other countries and what aspects of it can be identifiably applied to the Nigerian programme?

How do the various considerations (1-3) affect the planning and implementation of a training programme in particular institutional contexts? (This relates to the case studies reported in Chapters 7 and 8).

4. What decisions and resources are required to put the programme into operation?

What resources including personnel are available or required to carry out various approaches to the training of occupational therapists in Nigeria?

What important decisions are there to be made for example about the methods of selection of students, or numbers for enrolment?

5. Finally, how do these various considerations (1-4) enable us to plan the occupational therapy training programme for Nigeria?

A practical difficulty in beginning to think about these

questions is the limited publicly available information, literature and research on professional education of occupational therapists. The literature search found a shortage of information on the coherent, systematic and specific procedures for curriculum design in the training of occupational therapists. Rather, what has emerged and has been explored in a variety of literature in some detail, is the theoretical basis for the practice of the profession.

One can see these problems in the statements of two occupational therapists. Sym (1974), talking about the syllabus and examination system organized by the occupational therapy National Association in the United Kingdom, said:

Individual schools are at liberty to meet the requirements of the syllabus by evolving their own curricula. Time has not permitted the research necessary to arrive at a consensus of opinions giving principles by which curricula are evolved.

Woodside (1975) said:

Occupational therapists need to pay more attention to how other professions indoctrinate their students and how occupational therapy curricula are designed ...

These statements could be taken to mean the recognition that past methods of training occupational therapists were inadequate and of a need for change and for more detailed study of occupational therapy curricula.

1.3 What The Thesis Does

To answer the research questions, the account of the study has been structured and divided into four parts.

Part one (Chapters 1 & 2) explains to the reader the background to the study. This chapter (Chapter 1) introduces the reader to the study, why the study is done, why the study is problematic to the author, and how the thesis is laid out. Chapter 2 provides the reader with general background information about occupational therapy and gives an account of occupational therapy situations and needs in Nigeria.

Part two (Chapters 3 & 4) are designed to identify issues, to collect together information and ideas for the programme, and to delineate the overall research strategy. Hence, Chapter 3 looks broadly at curriculum and curriculum planning, selected theories of curriculum planning, and the idea of professional education, thereby setting the scene as to the direction in which the investigations in the study will proceed. This leads to establishing three important research questions in Chapter 4 and identification of who will be in the best position to answer our research questions; what information is required, why we are collecting the information and how the information collected will be used.

Part three (Chapters 5, 6, 7, 8) is also designed to collect ideas and information for our programme, and to answer the specific research questions stated in Chapter 4. Thus, using mail questionnaires and asking both specific and broad questions, the work reported in Chapter 5 sought to find out about the present occupational therapy situation in Nigeria as well as the views of the occupational therapists in the country. Again, using mail questionnaires and asking broad questions, the work described in Chapter 6 sought to answer the second research question and looked at the international requirements for training of occupational therapists and how training of occupational therapists is conducted in other countries. To complete the study, the work described in Chapter 7 was designed to answer the third research question through case studies of selected occupational therapy training programmes in Scotland. The reports of the case studies are presented in Chapter 8.

Part four of the thesis (Chapters 9, 10, 11) is concerned with developing the Nigerian programme and bringing the study to its conclusions. Chapter 9 draws together all the information gathered in the study and arrives at a model of curriculum for training occupational therapists in Nigeria. Chapter 10 discusses how the model will look in practice, and how the programme will be put into operation. Chapter 11 concludes the study by drawing upon the key characteristics of the study, what has influenced it and how the programme will be monitored for the first two to three years of its operation.

CHAPTER TWO

OCCUPATIONAL THERAPY IN NIGERIA

2.1 General Historical Background To Occupational Therapy

Occupational therapy is a health profession similar in general status to Physiotherapy.

The history of occupational therapy goes back to the days of ancient Greece, Rome and Egypt when the mentally disturbed were dealt with through organized activities. Temples were dedicated to which melancholics resorted in great numbers. Music, games, wrestling, riding, crafts and recreation were used in the treatment of insanity. The ancient Chinese also used physical exercise for the promotion of health because it was thought disease was caused by organic inactivity.

Bassan, Alfieri 1983; Edwards, 1980; Spackman, 1979; Macdonald, 1976, established in their writings that it was not until after the second world war that occupational therapy began to receive greater attention and wider use. The profession thereafter gained greater recognition from the increasing awareness of the need to rehabilitate civilian patients as well as disabled soldiers.

While it could be argued that occupational therapy developed along with the medical profession, it could also be said that it became a profession in its own right only after organized training was established. In the United States, occupational therapy training schools were started in the

mid 1920's while in the United Kingdom, the first occupational therapy training school was started by Elizabeth Casson in Bristol in 1930 (Edwards 1980). After this, and especially after the second world war, more schools of occupational therapy and occupational therapy associations emerged in several countries. The formation of the World Federation of Occupational Therapists (WFOT) in 1951 gave the profession further rapid growth and development. Since its formation, the WFOT has seen the establishment of more occupational therapy associations in several countries, training schools for occupational therapists and through its quadrennial world congresses provides a forum for occupational therapists all over the world, to discuss, debate, share experiences and disseminate information about the profession.

However, it would be inappropriate to think or suggest the road to professionalization of occupational therapy has been very smooth. Goldenberg (1984) commented:

A history of low diffidence and low confidence has marked the development of occupational therapy to date. A poor understanding of our role in health care by other professions and the public has led to reticence and underevaluation of occupational therapy as a health resource.

2.2 Description Of Occupational Therapy

Occupational therapy is a health profession similar in general status to physiotherapy. It is concerned with

people who have impairment of physical and/or psychological well-being. The impairment which can be either temporary or permanent can be caused by developmental deficiencies as in the case of cerebral palsy, muscular dystrophy and spina bifida; ageing processes as in the case of senility; physical injuries such as industrial and car accidents; and psychological or social problems. There are other types of impairments which occupational therapy in general is not concerned with: infective and parasitic diseases, endocrine, nutritional and metabolic diseases, diseases of respiratory, digestive and genito-urinary systems.

The occupational therapist may provide therapy with various purposes: CURATIVE, which involves restoration of capacity to function, for example, restoring the use of functions to a limb with a broken bone after surgical repair; REHABILITATIVE, which involves re-adaptation to one's life as an after effect of permanent disability, for example retraining and preparing amputees for employment, designing, adapting and training in the use of aids, special equipment, life and social skills; and PREVENTATIVE, which involves protecting existing function, for example showing an old lady who sustained an injury to her hip bones from a fall, how to move and protect it, thereby preventing further damage.

The occupational therapist uses a battery of therapies such as creative and practical skills as in crafts; special equipment such as arm mobilizers, rehabilitation

machines, lathes; leisure and recreation activities such as sport, play, drama, music, games, gardening; social/life skills activities such as communication, shopping, use of public transport, feeding, dressing, personal care; and training related to work activities such as work assessment, job skills and ethics and coping with demands of work, all of which depend upon the needs of the individual patient.

The therapies selected for an individual may aim to restore the impaired function, such as movement of a particular joint, or to assist the patient to participate in life as fully as possible despite the impairment. The overall goal then is to promote restoration of function and where this is not possible, to help the individual concerned adjust to his disability so that he/she can live as normal and independent life as possible in relation to work, home, community and pursuit of leisure.

In practice, an occupational therapist's work with an individual patient will pass through a series of stages:

1. A patient will be referred for occupational therapy either by doctors, nurses, physiotherapists or prosthetists.
2. The occupational therapist will then diagnose the patient's impairment by one or a combination of

methods such as reading already available information about the patient, using special tests, interviews, questionnaires, observation of specific tasks etc.

3. The therapist will formulate realistic goals for the patient on the basis of the diagnosis.
4. He will prepare a treatment plan, selecting and applying one or a combination of appropriate tasks, equipment, activities and materials to achieve the patient's goals.
5. He evaluates what effects the therapeutic intervention is having on patient's problems and takes appropriate decisions
6. He communicates the results of the findings effectively to the patient and those concerned, e.g. doctors, patient's referral source and, when necessary, their family and employers.
7. Therapists also perform administrative and supervisory functions in the care of the patients such as scheduling of patients for treatment, keeping records, determining treatment materials requirements etc.

2.3 The Present Situation of Occupational Therapy in Nigeria

In Nigeria, occupational therapy services have been available only since the early 1960's when a few Nigerians who went overseas to train returned to Nigeria to work.

The number of occupational therapists in Nigeria

Today, Nigeria, like both developed and developing countries, has an acute shortage of occupational therapists. Available data from the Nigerian Association of Occupational Therapists revealed that in 1972 there were only thirty-six professionally trained occupational therapists practising in Nigeria. This figure included both Nigerians and expatriates. This means in Nigeria, with a population of about eighty million people, there was (and still is) a ratio of one occupational therapist to about two million people.

Where and how they are employed

The first Nigerian occupational therapists were employed in hospitals specialising in the treatment of psychological disorders and physical injuries (psychiatric hospitals, orthopaedic hospitals). Today, the pattern of employment and area of practice have not changed according to the information supplied by the Nigerian Association of Occupational Therapists (Table 2.1). What has happened has been an increase in the number of

hospitals employing occupational therapists.

TABLE 2.1

Where and How Occupational Therapists are Employed in Nigeria

EMPLOYMENT AREA	NUMBER IN EMPLOYMENT
Psychiatric hospitals	10
University teaching hospitals	7
Military hospitals	4
Army resettlement centres	1
General hospitals	8
Orthopaedic hospitals	5
Federal Government Ministry	1
Total	36

Source: The Nigerian Association of Occupational Therapists, Lagos, 1982. Members List.

The small population of occupational therapists is not evenly distributed across the country. Of the present number, only two (a Nigerian and an expatriate) are employed in the whole of the northern part of the country which has about half of the country's population. This means about ninety-five percent of available occupational therapists are employed in the southern part of the country. This could be attributed to the fact that all Nigerian occupational therapists are from the southern part of the country. Some were trained or sponsored for training by their State governments and upon completion of their

training went back to their state of origin. Also, the majority of the occupational therapists are women and they tend to seek employment closer to their families. This has resulted in the concentration of occupational therapists in university teaching hospitals, psychiatric, general and orthopaedic hospitals in urban centres like Lagos, Ibadan, Benin, Enugu and other State capitals in the southern part of the country.

The status of occupational therapy in Nigeria

In the past, occupational therapy was under-utilized in Nigeria. This was because little was known about the profession and its possible contributions to health care. Both the health practitioners and the Nigerian public in general needed to be educated on the services the profession could render and the benefit that could accrue from its services. Lack of knowledge or experience of the profession has adversely affected the extension of professional practice to areas other than hospitals like, for example, rehabilitation centres, prisons, private practice, therapeutic programmes in schools, community or domiciliary work, consultative services to industries and training of occupational therapists. These are areas which have been found to be most rewarding both to individual occupational therapists and the profession in developing countries of the world.

While occupational therapy requires a wider process of public education in order to be more acceptable to the public in Nigeria, the other health professions such as nursing, physiotherapy and radiography do not. This is because the present organization and professional education of these groups has developed more or less independently in response to the needs of patients, the requests by doctors for particular services and the accumulated knowledge of practitioners of the profession.

The lack of awareness of the importance of occupational therapy can be attributed to several factors. At the governmental level, for instance, from a look at the health manpower situation in Nigeria from 1976 to 1983 (Table 2.2), it is apparent that for many years now the number of occupational therapists available in the country has not appeared in the annual statistics compiled by the Nigerian Federal Ministry of Health, whereas other health professions have. It is assumed from the 'error' that the Government did not have the data on occupational therapists, or the number of occupational therapists is too small to be represented in the data. Another factor is that the profession is late in developing in Nigeria. The majority of Nigerian doctors either through training or practice have no experience of occupational therapy.

The present sources of trained occupational therapists in Nigeria

At present there is no facility for the training of occupational

TABLE 2.2

Health Manpower in Nigeria: 1976-1983

PARAMETER	1976	1977	1978	1979	1980	1981	1982	1983
Registered Medical Practitioners	4,876	5,657	7,552	6,584	8,037	10,399	9,623	11,294
Dentists	182	213	277	269	285	379	425	588
Veterinary Surgeons	406	499	572	740	864	980	1,000	1,090
Nurses	19,229	20,852	22,501	24,607	27,941	29,962	33,598	37,112
Midwives	20,035	21,984	23,433	25,730	27,983	30,190	33,860	36,921
Psychiatric Nurses	650	726	795	860	959	1,097	1,268	1,437
Pharmacists	2,162	2,379	2,540	2,780	2,344	2,609	2,824	3,131
Medical Lab. Technologists	404	586	913	1,083	1,330	1,646	2,110	2,121
Radiographers	174	200	250	300	325	348	380	452
Physiotherapists	90	114	152	190	220	236	314	411
Dental Technologists	89	102	117	222	240	250	256	267
Dental Therapists	78	92	102	138	160	164	187	208
Medical Records Officer	75	102	109	111	123	148	165	171
Occupational Therapists	...	...	...	...	...	...	...	...

Key ... = Not Available

Source: Medical Statistics Division, Federal Ministry of Health, Ikoyi, Lagos, Nigeria.

therapists in Nigeria. The present occupational therapists trained overseas, mostly in the United Kingdom. Their training was either funded privately or by various governments in Nigeria.

The other source was (and still is) through recruitment of occupational therapist expatriates from other countries.

2.4 The Needs of Nigeria

The need of Nigeria as far as occupational therapy is concerned is to increase the number of occupational therapists practising in Nigeria so that more occupational therapy services can be made more widely available to those who need them. The present trends of occupational therapy professional practice in Nigeria indicate that although the number of occupational therapists practising in the country is very small, the potential demand has always been high and the actual demand has increased greatly in the past few years in all areas of health practice.

The expanding need for occupational therapy services in Nigeria comes about through several factors.

First, the profession is taking increasing responsibility within the health care fields. This is evidenced for example in the number of job vacancies. It is now

recognized in Nigeria as well as other countries that to establish a comprehensive health care service there must be an inter-disciplinary health care team. Health care policies in the country are under continuous review. The past few years have seen several educational and health developments in the country and all indications point to the fact that more changes are fast approaching. The Federal Government of Nigeria has restricted overseas study by not funding or approving foreign exchange for Nigerians who wish to pursue undergraduate studies abroad (West Africa Magazine, June, 1985). No new therapists have been trained abroad for the past five years or more and the number of those practising in Nigeria is decreasing.

Again, the Nigerian civil war of 1967-70 produced many victims who survived but with serious impairments. This created an increased demand for rehabilitation services to serve the needs of civilians and soldiers who had suffered amputation or other consequences of war-related trauma. Further, the oil boom of the 1970's in Nigeria brought changing patterns of wealth and health. Generally, there were improvements in socio-economic status and life expectancy in the country. Ogunseitani (1985) described the 1982 World Health Organization (WHO) fertility survey which put the average life span of Nigerians as forty-seven years. There is little doubt that life expectancy in the country will continue to be on the upward trend and with it will come more chronic illnesses and long-term disability which requires long-term continuous care.

A further demand arises because in Nigeria today mental illness is on the increase and people with mental illness are beginning to attract more attention. Some of the social institutions like the extended family system, marriage institutions and child rearing are breaking down. Drug dependence, alcohol abuse and college or school drop outs are on the increase. To this extent, and as shown in Table 2.3, the number of health services facilities and the population per hospital bed have increased steadily from 1971 to 1979. Finally, the growth of occupational therapy is called for in Nigeria where hazards of industrialization, and automation are on the increase. Simultaneously, the number of people injured in civil accidents has increased and in this group road traffic accidents prove to be an increasingly important factor. This is supported by the information supplied by the Nigerian Federal Office of Statistics on the number of reported cases and persons involved in road accidents in Nigeria between 1970 and 1978. The information (Table 2.4) showed a steady increase of reported cases of fatal road accidents from 1970 (2,042) to 1978 (7,287). It also showed that reported cases of serious road accidents increased steadily between 1970 and 1976. The peak was recorded in 1976 when the number increased to 20,944, more than double the figure for 1975. Then, in 1977, the figure fell sharply to 13,529 and started to increase again in 1978. The statistics also showed that between 1970-76, of reported cases of minor road accidents, there was a steady increase. When reported

TABLE 2.3

Health Service Facilities in Nigeria: 1971, 1976-1979

	1971	1976	1977	1978	1979
Number of Health Establishments	4,806	6,962	7,163	7,816	9,270
Number of Health Centres	193	391	398	508	596
Number of Health Clinics	1,859	1,961	2,109	2,428	3,059
Hospital Beds	20,221	56,049	57,944	61,360	69,750
Teaching Hospital Beds	2,232	3,657	3,724	3,812	4,186
Maternity Beds	1,350	11,884	12,560	10,261	14,241
Neuro-Psychiatric Beds	1,545	2,275	2,367	1,805	1,866
Orthopaedic Beds	703	892	927	739	754
Ophthalmic Beds	190	277	420	277	290
Population per Hospital Bed	1,370	1,360	1,350	1,300	12,000
Teaching Hospital Bed	29,000	21,000	21,000	21,000	20,000
Maternity Bed	48,000	6,400	6,200	7,200	5,000
Neuro-Psychiatric Bed	42,000	34,000	33,000	44,000	44,000
Orthopaedic Bed	93,000	85,000	84,000	108,000	108,000
Ophthalmic Bed	347,000	274,000	186,000	288,000	282,000

Source: Medical Statistics Division, Federal Ministry of Health, Ikoyi,
Lagos, Nigeria.

TABLE 2.4

Summary of Road Accidents in Nigeria Showing Number of Reported Cases and Persons

Involved: 1970-1978

YEAR	REPORTED CASES				PERSONS INVOLVED		
	FATAL	SERIOUS	MINOR	TOTAL	KILLED	INJURED	TOTAL
1970	2,042	4,235	10,389	16,666	2,895	13,154	16,049
1971	2,352	5,127	10,266	17,745	3,206	14,592	17,798
1972	2,855	7,041		23,287	3,921	16,161	20,082
1973	3,242	7,212	14,390	24,844		18,154	22,691
1974	3,686	7,654	17,554	28,894	4,922	18,163	23,085
1975	4,153	9,001	19,497	32,651	5,552	20,141	25,693
1976	6,541	20,942	26,414	53,897	7,717	32,199	39,916
1977	6,910	13,529	15,402	35,841	7,984	30,823	38,807
1978	7,287	13,720	15,114	36,111	9,252	28,854	38,106

Source: Federal Office of Statistics, Lagos, Nigeria.

cases of minor, serious and fatal road accidents were combined, they showed a steady increase from 1970-78, the period for which the information was available. In 1976, the number rose astronomically. The number of people killed between 1970 and 1978 also increased steadily and so did the number of people injured.

Notes

1. Minor cases of road accidents
 - These are cases in which at least one person sustained injuries and was treated in hospital and discharged immediately.

2. Serious cases of road accidents
 - These are cases in which no one was killed but at least one person sustained serious injuries resulting in his being admitted to the hospital.

3. Fatal cases of road accidents
 - These are cases in which at least one person was killed.

The major causes of death and hospital attendance, including admissions and out-patient cases, in Nigeria is comparable in variety to those seen in developed and under-developed countries although the balance of numbers may differ. This is indicated in Table 2.5. Though not all of these conditions are customarily seen by occupational therapists, several of them are conditions for which occupational therapists can provide, for example (5) mental disorders, (6) diseases of the nervous system and sense organs, (12) diseases of the skin and subcutaneous tissues, (13) diseases of the musculoskeletal system and connective tissues, (14) congenital anomalies and (17) accidents and violence.

Advances in medical care and health technology are demanding more of paramedical personnel, thereby creating growing needs and continuous use of the specialist skills and knowledge of occupational therapists in Nigeria.

The problems of the disabled in our society have become very complex involving physical, psychological, social and vocational factors. These problems were so great that the United Nations proclaimed 1981 the International Year of Disabled Persons. The Rehabilitation International, an organ of the World Health Organization, at its fourteenth world congress, held in Winnipeg, Manitoba, Canada, in June 1980, drew up a "Declaration of The Charter For The 1980s" based on the following:

TABLE 2.5

Federal Republic of Nigeria - 1980 Summary of Hospitals Morbidity and Mortality by Group of Diseases According to the International Classification of Diseases (8th Revision)

ICD SECTION	DISEASES GROUP	IN-PATIENT CASES			% OF TOTAL ADMISS-IONS	IN-PATIENT DEATHS			% OF TOTAL DEATHS	OUT-PATIENT DEATHS			% OF TOTAL ADDED DVICES
		MALE	FEMALE	TOTAL		MALE	FEMALE	TOTAL		MALE	FEMALE	TOTAL	
1	Infective & Parasitic Diseases	48,205	44,187	92,392	30.78	2,759	2,207	5,006	34.63	390,426	359,891	750,317	44.09
2	Isoplasms	1,069	1,429	2,508	0.86	173	111	284	1.96	2,909	4,033	6,942	0.40
3	Endocrine, Nutritional & Metabolic Diseases	2,768	2,515	5,283	1.76	299	310	609	4.21	16,027	14,597	30,624	1.80
4	Diseases of Blood and Blood-forming Organs	3,790	4,794	8,584	2.86	370	329	699	4.81	17,304	21,822	39,126	2.30
5	Mental Disorders	536	564	1,100	0.37	27	18	45	0.31	5,111	4,347	9,458	0.56
6	Diseases of the Nervous System & Sense Organs	3,650	2,959	6,609	2.20	291	243	534	3.67	54,608	54,017	108,625	6.38
7	Diseases of the Circulatory System	4,481	4,167	8,648	2.88	619	552	1,171	8.10	22,117	20,653	42,770	2.51
8	Diseases of the Respiratory System	15,069	13,327	28,396	9.46	824	691	1,515	10.48	57,058	52,113	109,171	6.42
9	Diseases of the Digestive System	18,402	14,736	33,138	11.04	281	291	572	3.96	81,952	64,612	146,564	8.61
10	Diseases of the Genito-Urinary System	4,807	6,247	11,054	3.68	151	95	246	1.70	16,448	27,761	44,209	2.59
11	Complication of Pregnancy, Child Birth & Puerperium	-	60,060	60,060	20.01	-	597	597	4.13	-	13,464	13,464	0.79
12	Diseases of the Skin & Subcutaneous Tissues	3,122	2,984	6,106	2.03	78	71	149	1.04	80,127	65,911	146,038	8.59
13	Diseases of the Musculoskeletal System & Connective Tissues	1,977	1,742	3,719	1.23	51	33	84	0.58	20,007	15,836	35,843	2.11
14	Congenital Anomalies	697	485	1,182	0.39	14	16	30	0.21	564	533	1,118	0.07
15	Certain Cause of Perinatal Morbidity & Mortality	1,493	3,491	4,984	1.66	346	573	919	6.36	1,782	1,975	3,757	0.22
16	Symptoms & Ill-Defined Conditions	6,203	5,914	12,117	4.04	557	499	1,056	7.30	72,569	78,716	151,285	8.89
17	Accidents, Poisoning & Violence	9,708	4,540	14,248	4.75	670	270	940	6.50	38,178	24,294	62,472	3.67
	TOTAL	125,977	174,151	300,128	100%	7,550	6,906	14,456	100%	877,187	824,595	1,701,782	100%

Source: Medical Statistics Division, Federal Ministry of Health, Federal Secretariat, Ikoyi, Lagos, Nigeria.

That the world population will increase to 6 billion by the year 2000.

That approximately one-third of the world population will by then be under fifteen years of age.

That 500 million people are disabled in the world today.

That in every country today, at least one person in ten is disabled by physical, mental or sensory impairment.

That today, more than 350 million disabled people live without the help they need to enjoy or live a full life.

(Vanderman, 1980)

These are staggering pieces of information, but on reflection, they are found to be no exaggeration of the plight of the disabled persons in society today, particularly in Nigeria.

Given the growing need for occupational therapists in Nigeria and the policy of self-sufficiency embarked upon by the Nigerian Governments, then it is not too difficult to understand why the Nigerian Government wants to establish a school for training occupational therapists. If it follows that the establishment of a programme for training occupational therapists in Nigeria aims eventually to solve these problems, this in itself raises some questions, which can be seen as a sharpening of the research questions in Chapter 1.

1. What general approaches are there to planning curricula, that may be relevant to planning the occupational therapy programme in Nigeria?

2. What information would be helpful in making decisions on the planning of a Nigerian occupational therapy training programme and how would the information be obtained?
3. How is occupational therapy in Nigeria practised and what would those involved recommend regarding a training programme?
4. What sorts of occupational therapists are needed in Nigeria? Are they the same as those produced in other countries?
5. What are the international requirements for the training of occupational therapists and do they have implications for the Nigerian training programme?
6. How is occupational therapy training conducted in other countries and what aspects of it can be applied to the training in Nigeria?
7. How do the various considerations (1-6) affect the planning and implementation of a training programme in a particular institutional context?
8. What resources, including personnel, are available or required to carry out various approaches to training for occupational therapy in Nigeria?

9. What important decisions do we make in the training concerning the question of student selection and numbers for enrolment, certification and accreditation?

There will be attempts in chapters three to nine of this thesis to provide answers to the issues raised above.

CHAPTER THREE

CURRICULUM AND PROFESSIONAL EDUCATION

3.1 Introduction

The purpose of this chapter is to consider some of the concepts and models which have been developed in order to aid curriculum planning, and then to discuss aspects of professional education, with a view to using such arguments to generate research questions and to give direction to this present study.

3.2. What Is Meant By 'Curriculum'

There has been much discussion about the meaning of the word 'curriculum'. Therefore, it would be helpful to identify some of the ways in which the term has been used. Lawton (1983) argues that:

Definitions do not necessarily help understanding but it is sometimes necessary to attempt to clarify meanings, especially where words are used in uniquely different ways in different contexts.

And Stenhouse (1984) suggests similarly that:

Definitions of the word 'curriculum' do not solve curricular problems, but they do suggest perspectives from which to view them.

The usage of the word varies considerably. The Collins English Dictionary defines 'curriculum' as:

A course of study in one subject at a school or college; a list of all courses of study offered by a school or college; any programme or plan of activities.

Barrow (1986) gives the origin and meaning as:

... coming from the Latin CURRICULUM which means the course or circuit that a race is to follow, implies the path or track to be followed or the course of study to be undertaken.

These definitions tend to emphasise the content aspect of the curriculum and curriculum planning as a task of choosing such content. Other writers, however, are more concerned with the purposes behind the content and the sequence of content. Hirst (1975), for example, took curriculum to mean a programme of activities designed so that learners will attain certain specifiable ends or objectives. Sockett (1976) quotes Gagne's view that curriculum is:

A series of content units arranged in such a way that the learning of each unit may be accomplished as a single act, provided that the capabilities described by specified prior units in the sequence have already been mastered by the learner.

The Munn Committee Report (1977) draws attention to a wider interpretation of curriculum, in terms of its 'formal', 'informal' and 'hidden' levels.

The formal curriculum consisting of courses organised within the school timetable. The informal curriculum consisting of activities like sport, debating, dramatic and orchestral production carried on under the school's auspices but outwith the formal teaching programme. The hidden curriculum, the whole ethos established by the atmosphere of the school, its code of discipline, the prevailing standards of behaviour, the attitudes adopted by the staff towards pupils, the values implicitly asserted by its mode of practice.

All the definitions so far considered deal primarily with the objectives, sequences and relationships of 'content'. Skilbeck (1982), in contrast, draws important attention to the ways in which the curriculum is put into practice in terms of resources and the activities of teachers.

Within these discussions of what curriculum is or is not, there is a progression towards fuller definitions. This is a result of the curriculum development movement in the 1960's when a lot of money and effort went into developing new courses and it became important to develop more precise models of curriculum. It was in that context that Stenhouse (1984) wrote of curriculum as:

The means by which the experiences of attempting to put an educational proposal into practice is made public. It involves both content and method and in its widest applications takes account of the problem of implementation in the institutions of the educational system.

From the various definitions, which we can only refer to as 'samples', it is easy to see why there has been some confusion about the term 'curriculum'. As many and varied as these definitions might be, Barrow (1986) has observed that:

There is no particular merit in being able to attribute different definitions to different people out of context. These definitions are in many cases rather cumbersome and stilted, besides being rather different from one another and, in some cases, a long way from the original meaning. What matters is a recognition of the point that various factors may impinge upon our attempts to present a particular content to students.

From this statement, what is therefore important is to develop a useful definition of curriculum for our particular purpose. In my view, the term has to include subject matter, the organisation of subject matter, its teaching and the determination of whether or not learning has taken place. To me, the four are interdependent in achieving a particular goal. We cannot talk of subject matter alone since we need to know in what form it should be presented to students. Likewise, we need to know what it is we are wanting to structure before embarking on structure and upon teaching. Furthermore, assessment is a necessary attempt to indicate that subject matter, structure and teaching are leading to a desirable outcome.

3.3 Curriculum Design

Curriculum planning appears to have generated a great amount of debate and controversy since the 1960's, in every sector of education from infant schooling to higher education and professional education. It is therefore possible to identify several views of the process. During the 1960's and 70's curriculum analysis and development models became a familiar feature of educational thinking. Curriculum was linked with the analysis of teaching and learning, and many curriculum plans or models were constructed to deal with the formal aspects of the curriculum.

Many writers, for example, Tyler (1949), Kerr (1968), Merrit (1972), Popham (1977) and Hirst (1973), argued that curriculum planning should follow certain basic steps and that there should be key elements within the design in order to achieve purposeful aims. Among these were the selection and statement of objectives, the selection and organisation of content, the selection of learning experiences and the choice of evaluation procedure. In the words of the Munn Report (1977):

All curricular design must start from fundamental principles, which are themselves inevitably matters of debate. What educational aims should the schools set themselves? What human capacities should they try to foster? What kinds of knowledge

are of most worth? These are perennial questions for curriculum designers, and over the years teachers, philosophers, psychologists, industrialists, educational theorists, defenders of traditions, revolutionaries and others have offered very different answers. The curricula adopted have usually represented attempts to reconcile some, if not all, of the conflicting views then current in society; and this points to the nature of the problem we ourselves are faced with.

It is against this general background that we have chosen to look in more detail at, firstly, three rather different approaches to curriculum design, and, secondly, at writings on the particular curriculum issues within professional education.

3.4. Models of Curriculum Planning

The Objectives Model

One of the earliest explicit approaches to curriculum planning, and one which has had a direct influence upon educational technology, has become known as the Objectives Model. Its development was influenced by behavioural psychology and it was systematised into a coherent rationale by Ralph Tyler, among others. Tyler (1949) suggested four fundamental questions underlying the planning of the curriculum: what educational purposes should the school seek to achieve? what educational experiences can be provided which are likely

to achieve these purposes? how can these educational experiences be effectively organised? and, how can we determine whether these purposes are being achieved?

These questions can be represented as four stages in curriculum planning:

Aims and objectives

Content

Organisation

Evaluation

The first stage of the model involves the identification of goals in terms of the behaviours to be developed in the learners. These goals or statements of intent are termed 'objectives' and must be specified before the further stages are considered. The formulation of objectives is the basis for curriculum planning, from which rational decisions can then be made about what should be taught, how content should be organised, and what assessment should be provided. The chosen objectives can be derived from various sources, such as the learners themselves, subject specialists or contemporary life. Lastly, their achievement depends, on the one hand, upon the cohesion of the four stages, and on the other hand, upon such factors as the quality of teaching, the characteristics of the learners and the nature and level

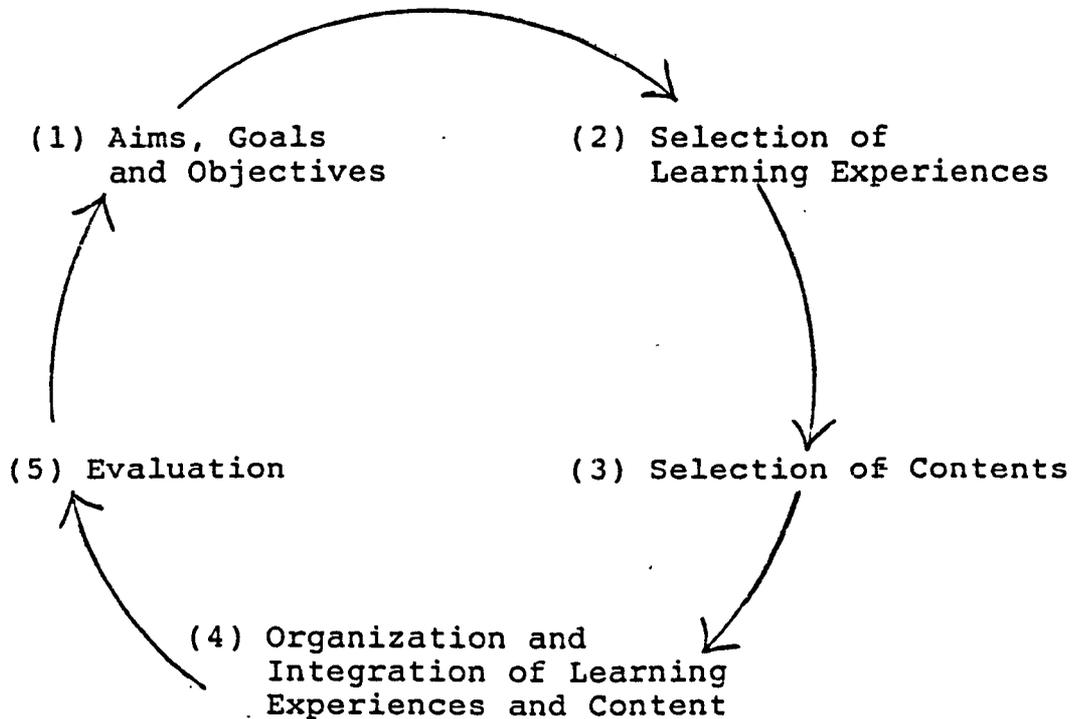
of resources.

The second stage of the model focusses on what should be learned in the curriculum. Here, the choice of contents should reflect both the sources of the objectives and the kinds of learning processes to be fostered.

The third stage, often referred to as methods and organisation, is particularly concerned with the relationships and reinforcements of the particular contents and with decisions as to appropriate teaching methods.

The final stage is concerned with ways of determining whether objectives have been achieved and with ways of indicating whether the curriculum requires modification.

The Objectives Model had much influence upon curriculum planning. Tyler's version was adopted and adapted by other curriculum theorists. For example, Jenkins and Shipman (1976) described Wheeler's curriculum model, which he based on Tyler's model. He converted Tyler's linear model into a cyclical one as shown in Figure 3.1:

FIGURE 3.1Wheeler's Simple Curriculum Model

Source: Jenkins and Shipman (1976) page 96.

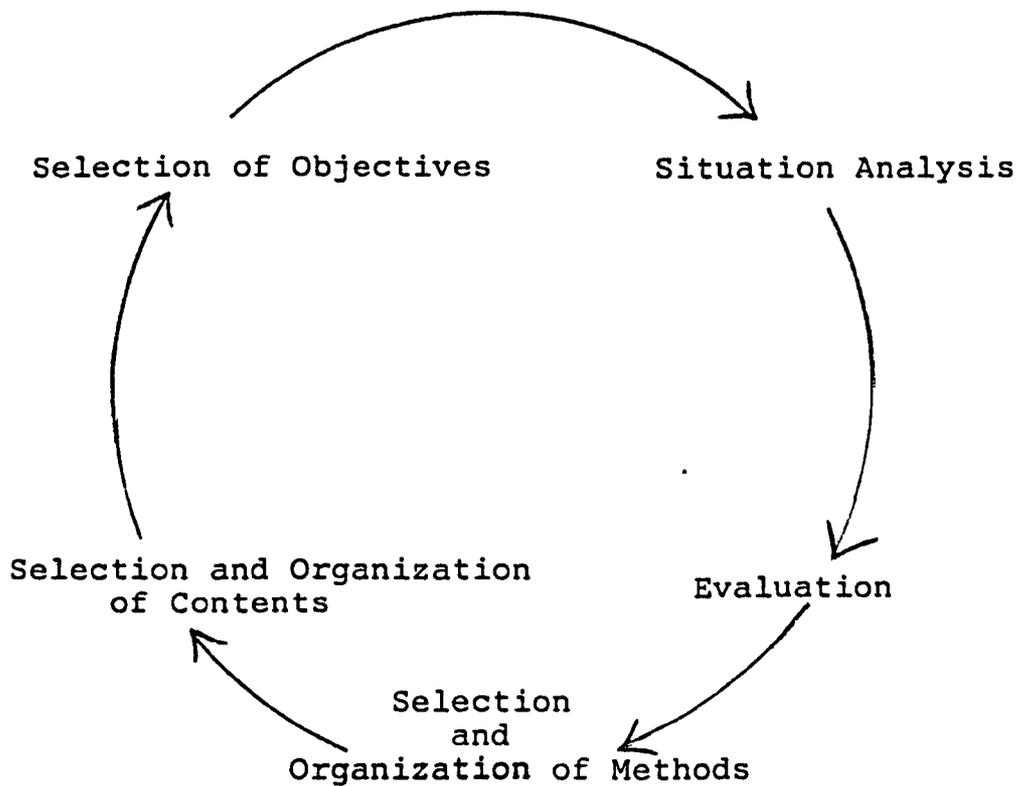
Wheeler's model emphasises the pre-requisite position of aims, goals and objectives and has built into it the basic assumptions that the end of education is to change behaviour. Thus, the model has five basic stages as illustrated in Figure 3.1.

Nicholls and Nicholls (1978) argued for a much wider and more comprehensive approach to curriculum planning. They argued that curriculum planning should include diagnosis and analysis of all the factors which make up

the total learning situation followed by the use of this knowledge. The insights derived from the situational analysis should be a major aspect of the process of curriculum development. This is shown in Figure 3.2:

FIGURE 3.2

Nicholls and Nicholls Revised Curriculum Process



Source: Nicholls & Nicholls (1978) page 21.

Since the formulation of the objectives model, a lot of work by educationists such as Popham, Mager and Grolund has been concentrated on making the first stage of the model as clear as possible so as to provide clear goals towards which students and teachers can work and in order to facilitate the measurement and evaluation of the results of the curriculum. Both of these concerns have led to an emphasis on behavioural objectives which specify, in terms of observable behaviours, what a student should be able to do, think or feel, as a result of a course of instruction. To this effect, Bloom, Krathwohl (1956, 1964), and their associates have produced three taxonomies of educational objectives to aid in the identification, description, classification and measurement of educational objectives. They distinguished three broad areas or domains: the cognitive domain concerned with intellectual abilities, the affective domain concerned with attitudes, feelings values and appreciation and the psychomotor domain which is concerned with motor skill.

The Objectives Model as a basis for curriculum planning has met a variety of criticisms:

Its somewhat rigid, sequential approach to stages in planning over-simplifies the complicated relationships between the stages.

The precise specification of objectives and the excessive concern with behavioural output leads to a very prescriptive view of what should be learned and how it should be learned.

It is unsympathetic to individual ways of learning and autonomy and initiative on the part of teachers and learners.

It tends to place a premium upon rote learning and upon judging success in terms of the learner's ability to reproduce those elements which can be assessed.

Despite the criticisms which have been made of the Objectives Model it has undoubtedly had beneficial effects upon thinking about the curriculum. It has helped to clarify the intentional nature of teaching, brought out the importance of sequence and relationship in curriculum planning, and helped to focus attention upon the roles of assessment in teaching and learning.

The Process Model

This model of curriculum planning has been most fully and persuasively argued by Stenhouse (1984). He suggested that a planning model should offer:

Principles for the selection of content - what is to be learned and taught, principles for the development of a learning strategy - how it is to be learned and taught, principles for the making of decisions about sequence, and principles on which to diagnose the strengths and weaknesses of individual students and to differentiate the general principles above to meet individual cases.

Stenhouse argued against the means-end approach of Tyler. For example, he was particularly opposed to the view that objectives should be stated in terms of students' behavioural change and to the view that it is possible or desirable to pre-specify the intended outcomes in precise behavioural terms. Rather, curricula should be planned in terms of the activities to be carried out by teachers as they seek to develop areas of knowledge and understanding. He asserted (Stenhouse 1984), that:

Within knowledge and arts areas it is possible to select content for a curriculum unit without reference to student behaviour or indeed to ends of any kind other than that of representing the forms of knowledge in the curriculum. This is because a form of knowledge has structure and it involves procedures, concepts and criteria. Content can be selected to exemplify the most important procedures, the key concepts and the areas and situations in which the criteria hold.

In a process-oriented classroom, the teacher makes fewer decisions and the students are allowed more choice of topic and activities. Nevertheless, the teacher's role is central.

The analysis of the criteria for worthwhile activities and of the structure of the activities deemed to be worthwhile appears to point much more clearly to principles of procedure in teaching.

(Stenhouse 1984)

In this model the outcome of learning is assessed after the learning has taken place, using criteria built into the system. The teacher is seen as a critic, not as a marker. Thus, the role of assessment is not to make students compete but to lead to and point out mastery. Also, the process model takes particular account of the individual learner.

The model has been criticised on several grounds; for placing too much emphasis upon the nature of areas of knowledge rather than specific content; for the problems it presents in assessing students; and for the reliance it places upon the quality and judgement of the individual teacher. As Stenhouse (1984) asserted, assessment

is concerned with difficult judgements and hence performance will vary from teacher to teacher. Critical assessment of work is an activity which exposes the strengths and weaknesses of teachers very clearly.

and the model:

is far more demanding on teachers and thus far more difficult to implement in practice, but it offers a higher degree of personal and professional development. In particular circumstances it may well prove too demanding.

It is important to point out that in contrast to Tyler's model, Stenhouse is concerned with an idea of education as an open-ended process. An educated person will have his horizons enlarged by education, therefore, the outcomes will be less predictable. Whereas Tyler's model is based on behaviourism, Stenhouse's owes more to a view of education as a process of initiation into worthwhile activities and the important forms of human knowledge. The teacher encourages and nurtures students in processes of exploring worthwhile experiences rather than prescribing the pre-determined information to be learned, and it emphasises active learning, learning by discovery and practical activities rather than rote learning. The essence of learning should centre on the process rather than the product, with the student being brought to an awareness of distinct forms of understanding and the ability to operate within these forms. The model, of course, makes important assumptions about the responsible role of the learner - his ability to seek knowledge independently, his capacity to grasp general principles and fundamental ideas and his self-motivation. Clearly too, the model implies methods of teaching and levels of resources which will permit individualised learning and the flexible scheduling of activities essential for meeting the individual needs of students.

The Situational Model

The Situational Model of curriculum planning is closely associated with the idea of school-based curriculum development. Skilbeck (1982), one of its main advocates sees it not as an alternative to the other two models but as a more comprehensive framework within which either the Objectives or Process Models may be encompassed. He argues that curriculum design should start with an evaluation of the actual situation in which development is to take place, leading them into the formulation of goals, selection of content, modes of implementation and evaluation. Learning should be developed jointly by the teachers and the students in the particular situation. According to Skilbeck (1982):

In the simplest terms, the school-based curriculum development claims that of all our educational institutions and agencies, the school and the schoolteachers should have the primary responsibility for determining curriculum content, the learning resources needed for this content, and teaching, learning and evaluation procedures.

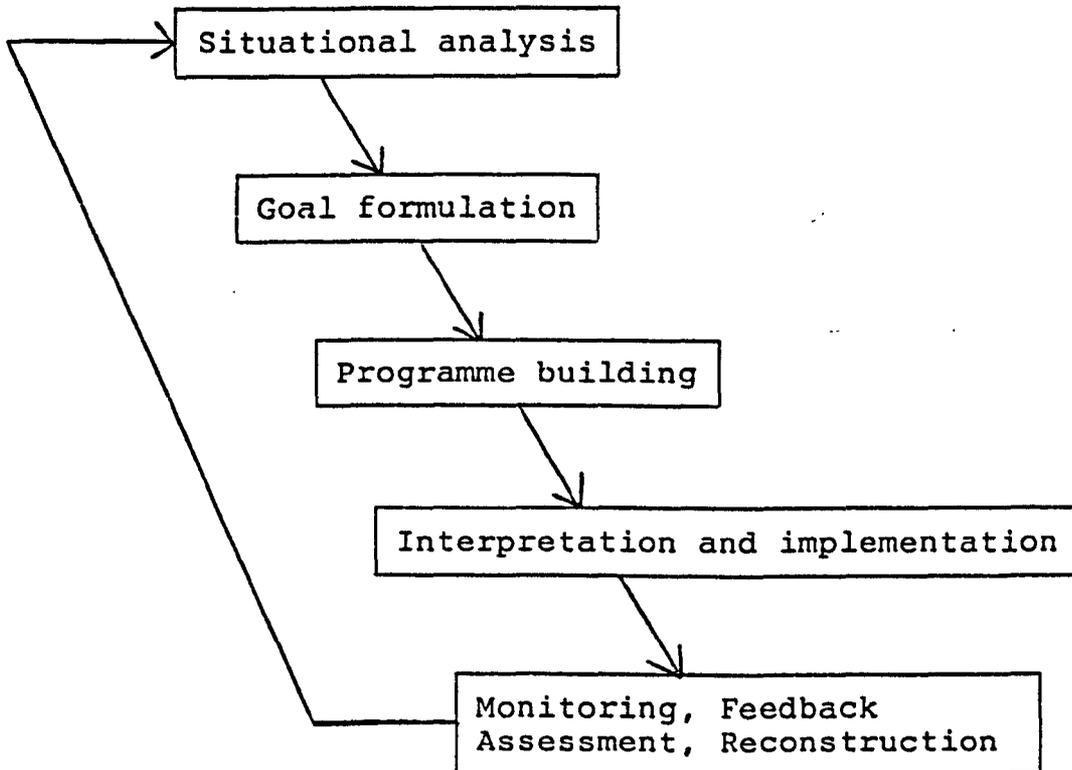
and:

School-based curriculum development does not centre all curriculum decisions on the school. It does, however, acknowledge or confer upon the school the right to design curricula, utilising whatever outside resources are available to them e.g. syllabuses and teaching materials prepared by national committees and

project teams. It also confers upon the school responsibility for assessing pupil performance, again drawing upon such external resources as national guidelines, standards and so forth.

FIGURE 3.3

Components of School-Based Curriculum Development



Source: Skilbeck (1982), page 27.

The above model has five major components. The analysis of the situation is of primary importance both in the development of a new curriculum or revising an old one.

Thus the situational analysis involves a review of the situation and analysis of the various interacting elements constituting it. These could be either external

or internal factors. The external factors to be considered include cultural and social changes, including parental and community expectations, employer requirements, community assumptions and values, educational system requirements, and challenges, for example, policy statements, examinations, local authority expectations or demands; the changing nature of subject matter to be taught; the potential contributions of teacher-support systems, for example teacher training colleges, research institutions and the flow of resources into the school. The internal factors to be considered include pupils, their aptitudes, abilities and defined educational needs, teachers, their values, attitudes, skills knowledge, experience, special strengths and weaknesses, school ethos and political structure, for example, common assumptions and expectations including power distribution, authority relationships, methods of achieving conformity to norms and dealing with deviance, material resources including plant, equipment and potential for enhancing them and perceived and felt problems and shortcomings in the existing curriculum.

The goal formulation embraces teacher and pupil actions including a statement of the kinds of learning outcomes which are anticipated. Such goals are derived from the situational analysis only in the sense that they represent decisions to modify that situation in certain respects. The goals imply and state preferences, values and judgements about the directions in which educational

activities should go.

The programme building comprises the selection of subject matter for learning, the sequencing of teaching-learning episodes, deployment of staff and the choice of appropriate supplementary materials and media

Interpretation and implementation are applicable where practical problems involved in the introduction of a modified curriculum are anticipated and then hopefully overcome as its installation proceeds.

The monitoring, feedback, assessment and reconstruction involve a much wider concept of evaluation than simply determining to what extent a curriculum meets its objectives. The tasks include preparation of assessment schedules, design of monitoring and communication systems and ensuring continuity of the process.

Skilbeck maintained in the model that curriculum planning can start from any of the five stages and that in a practical planning operation, the different stages can be developed concurrently. He also maintained that the model outlined does not pre-suppose a means-end analysis, rather it simply encourages teams or groups of curriculum developers to take into account different elements and aspects of the curriculum development process to see the process as an organic whole and to work in a moderately systematic way.

Among the criticisms levied against this model are that too many rights and responsibilities would be given to individual schools in designing the curriculum and assessing student performance. For these rights and responsibilities to be realized in practice requires a high level of organization and organizational skill which may not exist in some schools. Other criticisms of the model are that it can not be introduced as an isolated reform and as an effective reform unless other structural changes take place, for example, the provision of teachers' resource centres and that the model will produce disunity in policy, lack of uniform provision, varying standards and opportunities.

In the importance it attaches to the role of the teacher and to a democratic approach to curriculum development, Skilbeck's model resembles key features of the Process Model. Again, it seems to depend for its successful implementation upon both the quality of teachers and their readiness and ability to innovate. However, it does not prescribe, as the other models do, a particular methodology of teaching and learning, leaving such decisions to those working in the situation.

The preceding account and discussion of models for curriculum planning shows that there is no single agreed approach. As Barrow (1986) says:

There is no proper way to go about formulating new curricula or presenting them in general, that there are no good grounds for presuming that any curriculum should be set out in one particular kind of way, and that, in any case, one can not hope to formulate rules for curriculum design or to judge whether proposed rules are good ones, without reference to the question of what schooling and education are all about, as many curriculum designs seek to do.

And Mayhew (1971) stated:

There is no common theory of curriculum construction nor any generally accepted model (with the exception of the efforts of professional schools) to pattern education after the medical schools for professional education. Nor should there be, because there are essential differences in the professions and even individual schools serving the same professions have different missions.

Rather, their importance in relation to planning a programme for occupational therapists in Nigeria is as a source of ideas and questions.

3.5 Issues Arising From Curriculum Theories and Their Implications for Curriculum Development In Occupational Therapy

For the purposes of this study, curriculum theories are particularly useful for identifying issues that are likely to arise in developing an entirely new programme in Nigeria.

In planning a new curriculum, basic decisions have to be taken about the purposes it should serve. Such questions arise as: what should be the sources of the aims and objectives of the programme and how important is it to specify purposes in terms of specific behavioural objectives? In the model developed by Tyler, the emphasis is on the identification of specific objectives. One source of such objectives might be knowledge of the potential students and the likely manner in which their characteristics would relate to desirable standards to be reached through teaching and learning within the programme. On this basis it might be possible to identify the specific behavioural changes required in students between entry and completion of the programme. This would be relatively simple if there was experience from an already existing programme in Nigeria, but that is not so. We know little about the characteristics of the future learners. Another source might be the subject matter of experienced occupational therapists in Nigeria. This clearly has possibilities, although the present provision and the non-Nigerian training of the occupational therapists presently working in Nigeria means that this is a limited source. Two other possibilities arise from curriculum theory. Firstly, it may be appropriate to draw upon evidence from contemporary life in Nigeria, seeking aims and specific objectives which are particularly relevant to the cultures and problems of that society. This approach is developed in Skilbeck's model, where situational analysis offers a basis for curriculum

planning. For example, one would take account of features of the Nigerian situation which are more or less distinctive, such as health, situations in which occupational therapy is practised, social characteristics, resources and facilities. The other aspect of situational analysis is that occupational therapy is an international profession, and therefore, what is done in Nigeria must take account of international policy, requirements and standards, processes of certification and accreditation. This is the other 'situation' which has to be taken into account. The other possible source of aims and objectives is, of course, the body of commonly accepted knowledge called 'occupational therapy' within which are concepts, procedures, principles and skills which would provide a framework of purposes for the new programme.

Apart from the sources of aims and objectives, there is the issue of whether it is possible or appropriate to try to plan the curriculum in terms of sets of behavioural objectives or whether the main concern should be to plan sets of experiences which will initiate the students into good practice of occupational therapy. Each involves very different ways of planning the content of the programme, the forms of teaching and learning expected to take place and the use of resources and facilities. In principle, it might not be difficult to specify behavioural objectives in some parts of an occupational therapy programme, especially in certain areas of observable practical skills,

but major aspects might be very difficult to treat in that way, where complex abilities such as problem-solving, analysis and evaluation are involved.

Curriculum theories have equally important things to say about the nature and purposes of teaching and learning. On the one hand, there is a view of curriculum as a number of precise and specific elements of content which can be assessed with some measure of precision, and on the other, a view that teaching and learning is about the acquisition of the concepts, principles and procedures of the main bodies of knowledge which occupational therapy or other fields are composed of. Achieving these very different purposes would mean quite different positions on teaching methods, opportunities for students to learn, and necessary resources and facilities. They would also have different implications for what was assessed, how it was assessed and when it was assessed.

At this stage the writer is only concerned to identify these and other issues. The ways in which they are to be dealt with in a novel situation will be dealt with later, particularly in relation to empirical findings.

3.6 Professional Education and Curriculum Planning

Since the present study deals with the planning of a professional programme for occupational therapists, it is clearly important to consider the distinctive issues of professional education as well as those arising from general curriculum theory. Consequently, this section draws upon views about the nature of professions and the characteristics of professional education.

What is a profession?

In its widest sense a profession may be described as an occupation in which the practitioners have a command of a distinctive body of knowledge, skills and attitudes. Willensky (1964), in his writings on the growth of professions, argues that almost all professions have developed in a broadly identical way. The common stages have been:

The practitioners develop the field as a full-time activity.

Training is started in order to teach the would-be members the science and art of the profession.

A professional association of trained practitioners is formed.

The professional association is 'legalised'.

Rules are established to exclude the unqualified.

Within this broad process, professions become differentiated from other occupations in a number of ways. Paatero (1982) says that:

A profession is based upon a broad corpus of theoretical knowledge.

The practitioners work in a highly specialised service sector.

A profession carries out activities which the community regards as important to its well-being.

The social system within a profession is collegial.

The practitioners have specific credentials.

A profession has its own occupational and ethical guidelines.

To a considerable degree a profession exerts control over the recruitment of its members.

A profession defines the knowledge and skills constituting its field of activities.

There exists an institutionalised training system to provide future generations with the knowledge and skills constituting the profession.

The social and financial status of the members of a profession is relatively high.

Professional education

Views and practices of professional education have changed over the years. Dinham and Stritter (1986) have outlined three stages in its evolution: firstly, professional training based entirely upon an apprenticeship; secondly, professional training in formal settings separated from the profession's actual practice; and thirdly, the current mode of theory-based programmes incorporating both traditionally taught subject matter and integrated apprenticeship experiences. Within the current mode it is usual to find three components: the basic sciences and arts, the professional sciences and arts, and applications.

Although there is now broad agreement about the desirable

components of professional education, its actual provision comes in for frequent criticism, perceived failings of practitioners often being blamed upon their training.

Goodlad (1984) has observed:

Interest in the professions is as buoyant as ever. Often, this interest is expressed as criticism of architects who design buildings so badly that bits fall off; of dentists who seem keener to drill and fill than to promote preventative measures; of engineers and scientists whose cumbersome professional organizations seem unable to adjust to the speed of change demanded in information technology or bio-engineering; of solicitors who are accused of restrictive practices - (for exchange in conveyancing); of social workers whose Byzantine bureaucracies let babies die; of university lecturers who seem more interested in their research than their students. Is the education of intending professionals to blame for the deficiencies of professional practice?

3.7 Issues In Professional Education

In considering the planning of a new programme in Nigeria, there seem to be three major areas of issues arising from work on professional education.

Issues of National policy, professional needs and relationships:

The issues here concern the social obligations of the profession, the contributions it can make in solving social problems and the professional manpower needed to solve the problems.

Curriculum issues:

Among the particular matters here are the extent to which the programme should be 'academic' in content. On the one hand, an academic approach may alienate some members of the profession, but on the other, a reduction of academic content may jeopardise the profession's standing with other professions and runs the risk of ignoring accrediting bodies or international requirements. Then there is the problem of proportion and balance across the three components of professional education. Again there are issues about how we should teach in the curriculum, how students should learn, and who should teach. Related to teaching and learning are questions of assessment: what and how do we assess, and what use should be made of our assessments of students? Another fundamental matter is whether the prospective programme should concentrate either upon preparing for initial competencies or provide students with a broad basis of principles to facilitate their longer term development as practitioners. Some people, for example, may complain that spending too much time on understanding theory, research and principles may not develop the basic practical competencies needed in the young professional's first position. Yet another curriculum issue concerns professional specialisation, what form it should take, how much there should be, and how soon it should come in professional education? Some may argue that specialisation should have some place

in initial training while others may argue that it should come later, within the professional career itself.

General Issues:

There are a number of other issues, some of great practical importance in the planning of a new programme in Nigeria. Firstly where should the programme be located? Should it be based entirely within a university situation or use several locations, some in the field? What should be the length of the programme? This is an important question, both in relation to what are seen to be the professional needs, but also to matters of status and recognition. Mayhew (1971) makes the important point here that:

Even within a single profession, there are programmes of varying lengths, but there is no available evidence that length of programme makes effective practice. Nurses, for example, may pass the same examinations and enter into active practice after two -, three -, four -, or five year programmes. And both medical and law schools offer programmes of varying lengths determined by what undergraduate preparation is required for admission.

A very important practical and theoretical issue concerns the selection of appropriate entrants to the programme. What qualities should be expected, and what methods of selection should be used? Selection is important for several reasons. It concerns the maintenance of suitable

professional standards and the status of the profession. Abrahamson (1965) reported several research studies in which attempts were made to use predictors to identify rates of success or failure in professional education. A wide range of predictor variables were found, such as sources on achievement tests, intelligence tests, aptitude tests, pre-professional academic achievement, psychological traits, age, undergraduate grades and personal qualities noted in interview and so forth. The present writer (Osikoya, 1980) attempted to predict student performance from measures taken as part of the admissions process, and found that previous academic performance was one of the predictors of subsequent grades of students on occupational therapy courses. Other writers (e.g. Mayhew, 1971 and Goodlad, 1984) have also discussed the use of various predictors and have questioned their use.

Finally, there are important matters to be resolved in the case of a new programme when it comes to resources. What staffing, finance, equipment and materials will be needed if the professional programme in Nigeria is to be carried out successfully?

In this chapter we have outlined various views of curriculum and curriculum planning. We have also considered some aspects of writings on professional education and used these to identify a wide range of issues which have to be faced in planning a new programme

for occupational therapists in Nigeria. There are various ways in which such issues can be tackled. Later chapters focus upon three main sources of guidance. Firstly, what views may be held in Nigeria itself and what Nigerian evidence is there about the kind of professional education that would be appropriate? Secondly, major sources of guidance about professional programmes exist in the form of the papers and syllabuses of international and national bodies and institutions concerned with the education of occupational therapists. Thirdly, and perhaps most importantly, the actual policies and practices of particular colleges of occupational therapy are an essential source of guidance.

The next chapter is devoted to outlining the research strategy. The chapters that follow take up the three sources mentioned above and explore the evidence as it relates to the research questions.

CHAPTER FOUR

THE RESEARCH STRATEGY

4.1 Introduction

Since the final objective of this study is to develop a curriculum for the training of occupational therapists in Negeria, the immediate task is to identify the kinds of information needed to assist the planning. This chapter is concerned with generating specific research questions which will guide the collection of data and the methodology to be used.

4.2 Sources of Research Questions

The previous two chapters draw attention to a wide range of issues in curriculum planning. In chapter two the arguments for the need for occupational therapists in Nigeria were presented. These arguments led to the conclusion that one of the ways by which the need could be met would be by the establishment of facilities for training in Nigeria itself. This then raised the question of the type of training that should be provided, the type of occupational therapist that should be trained and the information needed at the planning stage.

In chapter three the discussion focussed first upon curriculum planning in general. It considered different models of educational processes. The latter part of the chapter concentrated upon aspects of professional education. Both parts raised many questions about the

form of the curriculum to be developed: the derivation and specification of objectives; the methods of teaching; the admission and assessment of students; and finance and resources.

4.3 The Research Methods

Since there is no Nigerian experience of training for occupational therapy to use, it seems important to ask members of the profession who currently work in Nigeria but had been trained elsewhere to give their views on the needs of the profession and on professional education. The specific research questions would deal with where they work, the types of patients they see, the methods they adopt in practising the profession and possible characteristics of a training programme in the country. Since the writer could not visit them in Nigeria, a questionnaire approach was necessary.

It was decided that the questionnaire should have three parts. Part one would deal with their present activities: their areas of specialism, sources of patient referral, the patient conditions they dealt with, and methods of treatment. The questions in part two were compiled in terms of the anticipated distinctive needs of the profession in Nigeria and the problems they might be facing. Part three was compiled to examine their views on the need for and type of training, arising from their reflections on their own training experiences and present practices.

Secondly, it was felt that information on international requirements on the training of occupational therapists might throw important light on the planning of a Nigerian programme. This would require the collection of international documentation from the World Federation of Occupational Therapists and occupational therapy Associations in various countries. A further aspect of international information was that available from the documentation available from occupational therapy training programmes in Britain. The information sought would deal with student admissions, types of institutions where training was provided, curriculum objectives, content and course structure, staffing and teaching methods, assessment and accreditation, and facilities. Comparable information from this variety of sources would bring out common features and distinctive practices of training institutions.

It was anticipated that the documentation available from the WFOT, occupational therapy Associations from various countries, and various British institutions would be very helpful in setting out the formal requirements and characteristics of these bodies but could not throw detailed light upon the actual processes of training. This could only be done by a study of a small number of occupational therapy programmes. So it was decided that the investigator should visit two Scottish departments and spend some time talking to staff and students. The main concerns here would be to collect information and

opinions on the policies and practicalities of training processes as seen through the eyes of those involved. Again, the issues raised would be about the actual processes in these departments concerning planning procedures, course contents, teaching methods, student assessment and course evaluation.

So, a different method was proposed for each aspect of the research. A postal questionnaire would be used to contact Nigerian practitioners. A general letter would be sent to the WFOT, occupational therapy Associations in various countries, and to the British institutions. And, for the detailed study of two departments, it was decided to use several visits during which interviewing and observation would be used.

In order to make the job of reporting and discussing the findings as systematic as possible, the three studies have been presented later in separate chapters. Chapter five deals with the responses to the questionnaires sent to Nigerian occupational therapists, chapter six focusses on the findings from the World Federation, occupational therapy Associations in various countries and the British training programmes; and chapters seven and eight discuss the methodology for the two case studies and the results of these visits to two Scottish departments.

CHAPTER FIVE

THE STUDY OF NIGERIAN OCCUPATIONAL
THERAPISTS' EXPERIENCES AND VIEWS

5.1 Introduction

As a part of this overall study, information was sought from occupational therapists working in Nigeria on their activities, training experiences and views on an appropriate occupational therapy training programme for their country. This chapter begins with an account of the method of investigation and then reports and discusses the findings.

5.2 The Method of Investigation

In obtaining the required information from the occupational therapists in Nigeria, mail questionnaires were used. It was recognized that the use of questionnaires in research had advantages and disadvantages. Some of the disadvantages are that respondents may not fully understand the contents of the questionnaire or what exactly the investigator wants from the questionnaire. Responses to questionnaires are often subject to different interpretations and information supplied by the respondents may sometimes be limited, casual, lacking detail and explicitness. Most importantly, there are the possibilities of the non-return or poor return of questionnaires which may distort the findings of the study. The advantages are that questionnaires, in principle, allow good sampling and generalization

and the method is very cheap compared to other methods of investigation. Using this method, one can determine the information one wants, ask people common sets of questions which are judged important and get comparable sets of responses. Answers are in the same form and consequently analysis is much easier. Postal questionnaires are useful where it is not possible to have a face to face interview with people. Although in this study other methods of investigation could have been used, for example, going to Nigeria to interview occupational therapists in the country, this was considered not practicable for reasons of finance and the time that would be involved. Using questionnaires would ensure that all occupational therapists were contacted and given the opportunity to express their views on matters that concern or affect their profession and the future of occupational therapy education in the country. Another concern was to ensure that the views of all the occupational therapists were obtained and not just those working in particular geographical locations or health areas in Nigeria.

Apart from the use of the postal questionnaire for the present purposes, the same method was employed to collect the data reported in chapter six from the World Federation of Occupational Therapists (WFOT), Occupational Therapy National Associations and Occupational Therapy Training Schools in the United Kingdom.

5.3 The Procedure

As a first step, a letter was sent to the Nigerian Association of Occupational Therapists, requesting a list of names and addresses of all occupational therapists practising in Nigeria. Subsequently a list compiled in 1982 was sent to me which showed that there were then thirty-six occupational therapists practising in Nigeria. Using this information, a questionnaire and accompanying letter (Appendices 5A and 5B) were then sent to each occupational therapist.

The questionnaire was divided into three parts. In devising the questionnaire, specific questions were asked in part one because this dealt with matters of basic information not opinion. In parts two and three, the questions provided for open-ended responses to allow the occupational therapists ample scope to express themselves and their views.

5.4 The Information Sought and the Rationale

The information sought in the questionnaire was divided into three parts.

In part one, the questionnaire was directed at seeking information about the situations in which occupational therapists practise in Nigeria. These included the

type of hospital or any other health related units in which they were employed, their sources of patient referrals, whether they saw themselves as working in specialist positions within occupational therapy, the frequency of cases of different types that they saw, occupational therapy methods they used and the frequency with which they used them.

In part two, opinions of the occupational therapists were sought on general occupational therapy issues, to include what they saw as health problems in Nigeria which could benefit from occupational therapy services but for which at present there was no adequate provision and also what further developments they considered to be necessary for occupational therapy in Nigeria to make its full contribution to meeting the health needs of the country.

Part three of the questionnaire was directed at obtaining the opinions of the occupational therapists on what they would consider an appropriate occupational therapy training programme for Nigeria. This involved asking the therapists to suggest from their experiences what they thought was neglected in their training, what was excluded that they would have found useful, and what, if anything, was included that they had never found useful. Since they had all trained outside Nigeria, some essential purposes of this part of the questionnaire were to find out whether they felt their training had failed in any particular way to

prepare them for the distinctive health problems which they had to deal with in Nigeria, whether there were any methods of training they had found particularly helpful, either arising from their experiences as trainee occupational therapists or from their subsequent professional experience, that they would recommend for inclusion in a training programme in Nigeria, and finally, what their views were on the structure and content of an appropriate training programme.

5.5 The Results

A total number of thirteen (31%) out of thirty-five (100%) questionnaires sent were returned. This response was despite sending two letters of reminder (Appendices 5C and 5D). Although this was a disappointing return, it should be borne in mind that this part of the study was done at a time of some political instability in Nigeria and in a country where there can be substantial difficulties in communication. From the thirteen responses, eleven were completed by occupational therapists, one was partly completed by a Medical Superintendent of one of the hospitals and one was returned uncompleted. One of the occupational therapists who responded to the questionnaire revealed that two of the thirty-five occupational therapists were no longer practising occupational therapy. This therefore reduced the number of occupational therapists working in

Nigeria to thirty-three. As mentioned earlier, there were three parts to the questionnaire and the reporting of results obtained will follow the same pattern.

Notes

For clarity in terms used in the results, the following words are defined thus:

OFTEN: means generally more than once per week.

OCCASIONAL: means generally less than once per week.

NEVER: means not at all.

The results in Table 5.1 showed that a good number of occupational therapists in Nigeria were employed in psychiatric specialist hospitals and university teaching hospitals. This supported the investigator's personal observation and experience of the situation in Nigeria. Although not represented in the Table, a good number were also employed in general and orthopaedic hospitals as indicated in Table 2.1 in Chapter Two.

(b) Are you working in a specialist position within occupational therapy? Please tick

YES	
NO	

If yes, please tick your area of specialism below:

Psychosocial conditions
 Physical conditions (general medical conditions)
 Orthopaedic/surgical conditions
 Paediatrics/neuro-developmental conditions
 Tropical diseases
 Other conditions (please specify)

In answering this question, only two respondents working in psychiatric specialist hospitals saw themselves as working in specialist positions within occupational therapy. This might have been because they attended only to psychosocial problems. Other respondents working in

psychiatric specialist hospitals claimed that occasionally orthopaedic, neurological and tropical conditions were referred to them and as such did not see themselves as working in specialist positions within occupational therapy. The respondents working in university teaching hospitals and military hospitals had the same opinion on grounds that they see all health conditions referred to them including psychosocial problems, physical, surgical, orthopaedic, paediatric and neurological conditions.

(c) Sources of patients referred to your occupational therapy department. Please tick✓those that are appropriate.

TABLE 5.2

Source of patient referrals to occupational therapy departments in Nigeria

	OFTEN	OCCASIONAL	NEVER
Your hospital from individual doctors	8	3	-
Your hospital from grand ward rounds	8	2	1
Your hospital from rehabilitation departments e.g. physiotherapy	3	2	6
General Practitioners	1	-	10
Rehabilitation Centres	-	3	8
Patients' Employers	-	1	10
Other sources (please specify)			
("patients' relatives")	-	1	-

The results in Table 5.2 showed that the therapists received patients for treatment mainly through the hospitals where they work. It is, then, appropriate to say that this supported the findings in Tables 5.1 and 2.1 that occupational therapy services in the country were hospital based.

- (d) For each of the types of diagnosis listed below, please indicate with a tick ✓ the frequency of cases referred to you as a part of your individual case load.

TABLE 5.3

Frequency of new referrals: psychosocial conditions

PSYCHOSOCIAL CONDITIONS	OFTEN	OCCASIONAL	NEVER
Neurotic disorder	9	1	1
Psychotic disorder	10	-	1
Personality disorder	8	2	1
Organic states	4	5	2
Drug/Alcohol abuse	5	4	2
Mental subnormality	1	5	5
Other (please specify)	-	-	-

TABLE 5.4

Frequency of New Referrals: Physical Conditions
(General/Medical Conditions)

PHYSICAL CONDITIONS (GENERAL MEDICAL CONDITIONS)	OFTEN	OCCASIONAL	NEVER
Diseases of cardiovascular system	2	4	5
Diseases of respiratory system	-	2	9
Diseases of urogenital system	-	1	10
Diseases of endocrine system	-	3	8
Diseases of locomotor system	3	2	6
Diseases associated with ageing	-	5	6
Other (please specify)	-	-	-

TABLE 5.5

Frequency of New Referrals: Orthopaedic/Surgical
Conditions

ORTHOPAEDICS/SURGICAL CONDITIONS	OFTEN	OCCASIONAL	NEVER
Fractures and dislocations	2	4	5
Amputations	1	3	7
Tissue injuries e.g. muscles, tendons, ligaments	2	1	8
Burns	2	2	7
Arthritis	1	1	9
Joint and bone diseases	1	2	8
Hand injuries	2	3	6
Other (please specify)	-	-	-

TABLE 5.6Frequency of New Referrals: Paediatrics/Neuro-
Developmental Conditions

PAEDIATRICS/NEURO- DEVELOPMENTAL CONDITIONS	OFTEN	OCCASIONAL	NEVER
Diseases of learning disorder	1	4	6
Diseases of developmental disorder	1	2	8
Congenital deformities	2	2	7
Other (please specify)	-	-	-

TABLE 5.7Frequency of New Referrals: Neurological Conditions

NEUROLOGICAL CONDITIONS	OFTEN	OCCASIONAL	NEVER
Cerebro vascular accidents	1	5	5
Head injuries	2	4	5
Peripheral nerve injuries	2	2	7
Spinal cord injuries	-	3	8
Other (please specify)	-	-	-

TABLE 5.8

Frequency of New Referrals: Conditions Associated with
Tropical Diseases Which Require Occupational Therapy

TROPICAL CONDITIONS	OFTEN	OCCASIONAL	NEVER
Malaria	-	-	11
Leprosy	-	2	9
Smallpox	-	-	11
Other (please specify)	-	-	-

The results shown in Tables 5.3 to 5.8 indicated that the therapists see a variety of health conditions within the psychosocial and physical medical conditions. We may say that the type of health conditions seen by individual therapists may vary depending upon the type of hospital in which the individual therapist was employed. Thus, for example, therapists working in psychiatric specialist hospitals would see mostly psychosocial conditions.

However, the results could not be taken as representative of health problems in Nigeria from our knowledge of the situation in Nigeria (Chapter 2, Table 2.5). Rather, the results may be representative of something else: conditions commonly referred to occupational therapy; or conditions that occupational therapists are good at treating; or conditions that occupational therapy manpower

in the country can absorb, since there are too few to absorb them all.

(c) For each of the methods of occupational therapy listed below, please indicate by a tick✓the frequency with which you personally use them

TABLE 5.9

Frequency of Use of Methods of Occupational Therapy

METHOD OF OCCUPATIONAL THERAPY	OFTEN	OCCASIONAL	NEVER
Activities of daily living (ADL)	7	4	-
Crafts and activities	8	1	2
Special occupational therapy equipment	2	4	5
Splintage	2	3	6
Projective techniques	6	1	4
Assessments: Home	4	2	5
Wheelchair	3	2	6
Job	6	2	3
Other methods (please specify) physical exercises and recreation, group discussion, play reading, drama, social skills training and job training.			

In Table 5.9, splintage, specialist equipment and wheelchair assessments were found to be least used. The explanation could be because of the difficulty in obtaining these items in the country. Also, this particular result might have

been affected by the type of patients seen by the therapists. For example, a therapist working in a psychiatric specialist hospital and treating mainly psychosocial conditions would have little use for splintage. However, this should not be taken to mean that occupational therapists working in psychosocial conditions do not have knowledge of use of splintage in occupational therapy.

Part Two

This part of the questionnaire sought from the occupational therapists their OPINIONS ON OCCUPATIONAL THERAPY ISSUES IN NIGERIA. The information sought under this section together with the results were as follows:

- (a) In your judgement, are there health problems in Nigeria which could benefit from occupational therapy services but for which we do not at present have adequate provision? Please list any such conditions.

In answer to this question, the conditions mentioned by seven of the occupational therapists were psychiatric problems, mental handicap, children with physical and psychological disorders and handicap problems, cerebral palsy, neurological conditions; orthopaedic cases, industrial accidents, burns and amputations; general hospital cases, foot diseases, diseases of the respiratory

and endocrine system; residents in homes for the handicapped, orphanages, centres for the blind, rehabilitation centres, leprosy settlements and prisons. The consensus of four of the therapists on the same question was that there were many things occupational therapists could do in the country but for shortage of occupational therapy manpower and finance.

- (b) In order that the occupational therapy profession can make its full contribution to meeting the health needs of Nigeria, what further developments do you believe to be necessary, e.g. the extent to which the profession should expand, the kinds of skills which the profession needs to develop fully, different kinds of provision there might be to enable the profession to do its job better, for example more varied places for therapists to work, more technical support staff, more or better equipment.

The occupational therapists in their responses suggested that it is essential to have facilities for the training of occupational therapists in Nigeria to solve the manpower shortage of both occupational therapy professionals and support staff, and availability of funds to support such a training programme and maintain existing occupational therapy clinical services. They also mentioned that there is a need for the development and provision of occupational therapy equipment and materials locally within Nigeria to suit the Nigerian local health

requirements in treatment procedures, establishment of more departments of occupational therapy in hospitals throughout the country, research in occupational therapy, possibilities for occupational therapists to serve on various health boards, social ministries, local government boards and institutions, co-ordinating the services of occupational therapy and the services provided to reach the rural areas in the country, and finally to educate hospital staff and the public on the roles and functions of occupational therapy.

Part Three

This part of the questionnaire sought from the occupational therapists their OPINIONS ON AN APPROPRIATE OCCUPATIONAL THERAPY TRAINING PROGRAMME FOR NIGERIA. The information sought under this section together with the results, was as follows:

- (a) From your experience as an occupational therapist, what do you think was neglected in the following aspects of your own training - the THEORY, PRACTICALS and CLINICAL content of the training programme and the teaching methods employed in the programme? What was excluded that you would have found useful? Also, what, if anything, was included in your training that you have never found useful?

The ten occupational therapists who responded to this question expressed satisfaction with the theory, practical and clinical aspects of the training they had. They also indicated there was nothing included in their training that they did not find useful in the course of the practise of the profession. However, some said that they would have found it useful if the contents of their training had included a brief introduction to research methods, the study of pharmacology, reading of X-ray films to identify problems, the opportunity to observe surgical procedures, the study of tropical diseases and the application of occupational therapy to such conditions, health policy in Nigeria and the development of community health services. More attention should have been given to health problems in Nigeria. The teaching would have been improved by more use of audio-visual aids, more emphasis on practical knowledge in the laboratory, occupational therapy students receiving lectures with medical and para-medical students and visits to work centres and patients' homes to assess problems. The techniques (practical skills) taught during the training were found to be very good, but their application needed adaptation to different situations, such as those in Nigeria. For example, some techniques like art and drama were found by the therapists to be very useful as treatment media in Europe but not in Nigeria. Some of the therapists also found that the lifestyle and background of Nigerians, which could have served as sources

of techniques (practical skills) in their training were not used. One of the respondents particularly mentioned that there were too many subjects in the training which required detailed knowledge to be grasped by students within a short time, for instance, the central nervous system needed much study time and could only be understood with real practical knowledge.

(b) As an occupational therapist working in Nigeria, have you found that your training failed in any way to prepare you for the distinctive health problems which you had to deal with in Nigeria?

Again, the ten respondents expressed satisfaction with the training they had had, found the training very useful, basic and adequate. The problems encountered after training, as expressed by some of the respondents were those of cultural factors and adaptation of treatment to local health conditions in Nigeria. Shortage of funds, materials and equipment. Medical problems were seen to be similar all over the world, the only difference being those of environmental and cultural factors. Hence, with modifications, it has not been too difficult to apply the same solutions to most health problems in Nigeria.

- (c) Are there any methods of training that you have found particularly helpful, either from your experience as a trainee occupational therapist or from your subsequent professional experience, that you would recommend for inclusion in a training programme for Nigeria?

The replies of the six respondents to this question were that the training should be undertaken in a university as a degree course and should be broad-based. During training, students should be given early contact with a wide variety of patients and multi-disciplinary staff. It was also recommended that domiciliary work should be included in the training, more time be devoted to the practical aspects of the training, and the training programme should have provision for in-service training and post-graduate work.

- (d) Please give your views on the ways in which the different parts of the training programme should be related to one another, e.g. the way in which THEORY, CLINICAL PRACTICE and TECHNICAL training should be related; the order in which different parts of the training are taught and what the balance of time given to each part should be?

The eight respondents to this question agreed that the theory, clinical practice and technical aspects of the

training programme are equally important and all should receive equal attention during the training. There were many suggestions as to the order in which the different parts of the training should be taught. For example, they included the view that the theory should be taught before the clinical practice, that theory and practical courses should be taught simultaneously as the first phase of the training to be followed by clinical practice, that practical courses should start from the first day of training and continue till the end of the training and that the clinical practice should be spread throughout the whole training. Two of the occupational therapists suggested an outline of course structure, to include in the first year the study of anatomy and physiology, psychology, occupational therapy techniques, four to six weeks initial placement in hospital clinical practice and part one examination. The second year would include the study of general medicine and surgery, psychiatry, medical sociology, orthopaedics, communication and management, occupational therapy techniques, three months clinical practice and part two examinations. The third year of the training to include a variety of clinical practice experiences, work projects and final examinations.

- (e) Do you have any further comments which you think might help me in the planning of a training programme e.g. questions of control, finance, student assessment?

The comments made by the nine respondents to the question were as follows:

Advice on the training of occupational therapists must be sought from the World Federation of Occupational Therapists (WFOT). The training programme in Nigeria must be university-based and the training institution must work closely with the occupational therapy clinical departments. The basic admission qualification into the training must be the General Certificate of Education, Advanced Level, and should be reviewed from time to time. The students' assessments should be on a continuous basis, assessment of students should be the joint responsibility of the school and the Nigerian Association of Occupational Therapists' Board or Committee on Education and there should be evaluation reports on every student at the end of every clinical placement. The Federal Government of Nigeria should finance the programme. The Nigerian Association of Occupational Therapists should have control of the school, assess students and award certificates and students should be given some financial allowance when they are in their final year.

From the overall result, we have to ask the questions:

(1) How much does it matter that a small proportion answered and that this did not include those in general hospitals (Table 5.1), whom other information (Table 2.1) suggests would form the majority?

(2) How should this bias affect the interpretation?

The answers to these questions lie in the purpose of the study. The results can not be taken as giving us a map of occupational therapy activity on which we can base our planning. All it can do is suggest ideas for consideration and possibly shape our thinking. Another contribution of the study is that it allows one to make some estimate at what would be seen as an acceptable training programme by the existing professionals, indicating what would gain their support when providing supervision and the entry of new trainees into the profession.

Although the response was limited, a substantial amount of information was obtained. From my own knowledge of the Nigerian situation through discussion and professional meetings, those who responded seemed to have been those who are active in the profession's national association and those who have been very vocal about developing training provision in Nigeria. However, from personal knowledge of Nigeria, those occupational therapists working in general hospitals see both physical and psychosocial conditions, as did those who responded to the questionnaire. Hence we can say the referrals are reasonably representative of what is happening in occupational therapy in the country. However, we have to be cautious of how we interpret the results. Any generalization we might wish to make has to be indicative rather than conclusive. Nevertheless, such indications

can make a useful contribution to the overall thinking in this study about future provision. The more important general indications contained in the result are that:

1. The occupational therapists were employed in a variety of health establishments in Nigeria.
2. The referrals of patients for occupational therapy and the services of the profession itself are hospital-based.
3. The occupational therapists work as generalists rather than specialists. They would see different types of health conditions referred to them irrespective of the type of hospital in which they are employed.
4. The therapists are working mainly in two areas of health problems - physical and psychosocial dysfunction and in performing their functions they use a variety of occupational therapy methods.

A lot of interesting things have come out of this survey which should be of value in this study, although answers to some of the issues raised might not be provided in the present study. The survey has brought to light the importance of taking into consideration Nigerian customs,

social, economic and health needs. It has also been particularly helpful in indicating general support for university-based training which should be comparable in standard and quality to that obtained abroad, and in indicating the roles of the Nigerian Government, the Nigerian Association of Occupational Therapists, and finally the importance of the WFOT in planning training.

Thus, the findings can influence the content and structure of a possible programme in Nigeria and can also forewarn those who will be involved in the training with important policy decisions to be made. For example, in planning the programme, course content and structure could be considered in the light of health conditions the therapists see and to which they are most likely to make contributions, and the accumulated body of knowledge of the profession and the skills and knowledge to be emphasised on the basis of how the therapists function in performing their duties.

CHAPTER SIX

THE STUDY OF INTERNATIONAL AND BRITISH DOCUMENTATION

occupational therapy national associations. A list supplied showed that there were 36 occupational therapy national associations who were members of the WFOT.

Using this information, an identical questionnaire and accompanying letter was then sent to the WFOT and the national associations seeking information about their policies on the training of occupational therapists, especially on matters such as student admission, types of training institutions, curriculum, faculty arrangements, facilities and accreditations. The details of the letter and the questionnaire are in Appendices 6A, 6B and 6C.

Although Nigeria is not a member of the WFOT, the same letter and questionnaire was sent to the Nigerian Association of Occupational Therapists. Unfortunately they did not reply. In obtaining British documentation, a letter was sent to the British Association of Occupational Therapists requesting lists of names and addresses of all occupational therapy training schools in the United Kingdom. A list supplied showed that there were 15 schools in the United Kingdom. Subsequently, a questionnaire and accompanying

Note The World Federation of Occupational Therapists (WFOT) is the international body responsible for the occupational therapy profession.

letter was then sent to each school requesting information about their training programmes and matters such as student admission and enrolment, curriculum, staffing and facilities. The details of the letter and the questionnaire are in Appendices 6D and 6E.

6.3 The Results

The results are presented in the form of reports, with tables, figures and diagrams showing similarities and differences in each of the areas on which information was sought. It is, however, important to state that the information sent to me was not generated specially for this study but rather came from materials available on request at the time of the investigation. Accordingly, the replies are either in the form of personal communications, brochures and/or publications of the WFOT, the national associations and the training schools. It is from these documents that the following results were extracted.

6.3.1 The World Federation and National Associations

In response to the questionnaire, the WFOT sent one of its prepared documents Recommended Minimum Standards for the Education of Occupational Therapists. This document has been prepared by the WFOT to answer requests for advice

or guidance in establishing occupational therapy training programmes, and to serve as an international standard for countries where such programmes are already in existence.

Eight out of thirty-six associations replied to the questionnaire. They were:

1. Associazione Italiana Di Terapia Occupazionale.
2. Australian Association of Occupational Therapists Incorporated.
3. Canadian Association of Occupational Therapists.
4. College of Occupational Therapists, United Kingdom.
5. Icelandic Occupational Therapy Association.
6. Japanese Association of Occupational therapists.
7. The American Occupational Therapy Association Incorporated.
8. Verband der Beschäftigungs und Arbeitstherapeuten (Ergotherapeuten) e.V.

From the replies, several observations were made. The number of responses were small; all the responses were from developed countries. This leads to asking the following questions: Could the number of responses have been limited by language translation difficulties? Do some national associations have no policies or documentation on professional education of occupational therapists? Are some national associations not involved in the professional education of occupational therapists? Do some countries have only national associations and no training school, or could it

be the reverse?

Given a small return, this must bias the material we got, the bias being that these are advanced, rich countries with a long history of occupational therapy. We cannot use any of them as a fully appropriate model for a developing country such as Nigeria, but we can borrow ideas from their experience and practices. One or two responses from the under-developed or third world countries might have provided interesting comparisons.

Even among the respondents, greater information was sent by the English-speaking countries, like Australia, Canada, United States, United Kingdom, while limited information was received from Italy, Japan, the Federal Republic of Germany and Iceland.

The main features of the findings and their overall summary are as presented in Tables 6.1 to 6.6.

Student Admission

The WFOT recommends student admission requirements but each country in the Federation has slightly different criteria for selecting students (Table 6.1). The general indication was that, within each country, student admissions were the responsibility of individual training institutions. Where training is in higher institutions,

TABLE 6.1

WFOT/National Associations: Recommended Student Admission Requirements

WFOT/NATIONAL ASSOCIATIONS	STUDENT ADMISSION
WFOT	<p>Minimum age of 18. Good health, both physical and mental. Completion of recognized secondary school education. Capable of doing advanced studies. Maturity, emotional stability, satisfactory attitudes towards social responsibilities, ability to communicate. School work records and references. Personal interview when geographically possible.</p>
AUSTRALIA	<p>Responsibility of individual schools.</p>
ICELAND	<p>No statement of requirement</p>
U.S.A.	<p>In accordance with generally acceptable practice of the training institution. Shall be joint responsibility of the Director, the faculty of the programme and the appropriate administrative officials.</p>
. U.K.	<p>Six General Certificate of Education subjects (or equivalent) to include English language and a Science subject, and at least two other academic subjects at Ordinary level and one academic subject at Advanced level <u>OR</u> six Scottish Certificate of Education subjects of which three must be at Higher grade. These should include English and a Science subject and at least two other academic subjects. Individual schools have additional entry requirements.</p>

TABLE 6.1 cont'd.

WFOT/National Associations: Recommended Student Admission Requirements

WFOT/NATIONAL ASSOCIATIONS	STUDENT ADMISSION
CANADA	In accordance with the general admission procedures of the university concerned. Shall be the joint responsibility of the appropriate university officials and members of the occupational therapy faculty.
JAPAN	High school graduation.
GERMANY (Federal Republic)	Admission age 18, after completion of a secondary education. Beyond that, each school has its own admission requirements.

like the universities, admissions are in accordance with the admissions procedures of the university concerned. Where specific academic qualifications for admission are laid down by the national association, the individual training institutions still have or demand additional requirements. Completion of secondary school education and a minimum age of eighteen were emphasised by some countries.

Training Institutions

The WFOT recommendation on the locations appropriate for the training of occupational therapists are that if the training is in a hospital, it is essential that it be in a teaching hospital preferably affiliated with a medical school. Information obtained from some countries, like U.K., Japan and Germany, shows that occupational therapy training is conducted in a variety of settings, for example universities, hospitals and some private settings. In Canada and the U.S.A. it is recommended that training should be located in a university (Table 6.2).

The length of training varies from country to country, depending upon the qualifications awarded at the end of the training (Table 6.3).

TABLE 6.2

WFOT/National Associations: Recommended Training Institutions

WFOT/NATIONAL ASSOCIATIONS	TRAINING INSTITUTIONS
WFOT	If a school is established in a hospital, it is essential that it be in a teaching hospital, preferably affiliated with a medical school.
AUSTRALIA	Separate health science institutions that have some affiliation with a university medical school is the usual format.
ICELAND	Should always be in a university and grant a university degree.
U.S.A.	Must be located in a college or university authorised to grant the Baccalaureate or higher degree.
U.K.	No requirements. Occupational Therapy Schools are either run privately or are part of larger educational institutions, or come under the National Health Service.
CANADA	In a university which includes a medical school accredited by the Canadian Medical Association and which is authorised to grant the Baccalaureate or higher degree.

TABLE 6.2 cont'd.

WFOT/National Associations: Recommended Training Institutions

WFOT/NATIONAL ASSOCIATIONS	TRAINING INSTITUTIONS
JAPAN	No requirement. Some schools are university based, some are private and either hospital or non-hospital based.
GERMANY (Federal Republic)	No requirement. Some schools are affiliated to hospitals, others are private, municipal or run by various organisations.

TABLE 6.3

WFOT/National Associations: Length of Programme/Qualifications Awarded

WFOT/NATIONAL ASSOCIATIONS	LENGTH OF PROGRAMME
WFOT	Required to cover at least 3600 hours spaced over 120 weeks and extend over a minimum period of three years.
AUSTRALIA	3½ years Bachelor Degree 3 years Diploma in Occupational Therapy
ICELAND	Should be 4 years
U.S.A.	4 years Bachelor Degree
U.K.	3 years Diploma College of Occupational Therapists
CANADA	3-4 years depending on the training institutions. Bachelor Degree.
JAPAN	3 years. Diploma in Occupational Therapy
GERMANY (Federal Republic)	3 years. Diploma in Occupational Therapy

Curriculum

Full information on curriculum content, programme aims, objectives, methods of training, course structure and assessment procedures could not be obtained from the national associations. These were seen as the responsibility of individual training schools.

However, a general overview of the requirements of WFOT and four national associations, namely U.S.A., U.K., Canada and Japan, on curriculum content shows similarities.

These are stated in very broad terms and include:

1. Biological, Behavioural and Health Sciences

Includes the study of anatomy, physiology, kinesiology, neuro-anatomy, neuro-physiology, psychology, sociology, psychiatry, medicine and surgery.

2. Principles, Theory and Application of Occupational Therapy

Includes the study of professional procedures, practical skills and their uses as therapeutic tools, applications of occupational therapy theory to practice, principles of management.

3. Clinical Practice/Fieldwork Experience

The WFOT emphasised that the structure of the course should be:

- 25% - Biological, Behavioural and Health Sciences
(c. 800 hours).
- 50% - Principles, Theory and Application of Occupational
Therapy (c. 1800 hours).
- 25% - Clinical Practice/Fieldwork Experience (c.1000 hours).

In determining the distribution of teaching hours within these three sections, the WFOT requires the educational programme to provide balanced training for the treatment of both physical and psychiatric conditions and for preventive and community programmes. In clinical practice, approximately the same time is recommended for experience with patients receiving treatment for physical and for psychiatric conditions. The amount of time recommended for clinical practice by the national association varies as shown in Table 6.4

Faculty

The WFOT recommends that personnel who train occupational therapists should include occupational therapists, medical and allied personnel (Table 6.5). The recommended qualifications for the head of training vary from country to country. While a country like the U.K. has no requirement as to faculty characteristics, others, like the U.S.A. and Canada simply recommend faculty teaching staff to include occupational therapists. Only Iceland specifies that at

TABLE 6.4

WFOT/National Associations: Recommended Length/Structure of Clinical Practice

WFOT/NATIONAL ASSOCIATIONS	CLINICAL PRACTICE
WFOT	1000 hours. Equal time recommended for experience in treatment of physical and psychiatric conditions.
U.S.A.	6 months (minimum). To include experience in a wide range of client ages and a variety of physical and mental health conditions.
U.K.	Total of 1200 hours. 400 hours in hospitals specialising in treatment of physical conditions. 400 hours in hospitals specialising in treatment of psychiatric conditions. 400 hours in either or both of the above fields or in one allied to them.
CANADA	1200 hours (minimum) required. Must offer a balance of experience between physical and psychiatric conditions.
JAPAN	Last 6 months of the training devoted to clinical practice.

TABLE 6.5

WFOT/National Associations: Recommended Faculty

WFOT/NATIONAL ASSOCIATIONS	RECOMMENDED FACULTY
WFOT	<p>Medical and allied personnel for instruction in medical and related subjects. Occupational therapists for instruction in occupational therapy courses. Instructors in therapeutic activities, preferably occupational therapists. Secretarial assistance. Director of programme should be an occupational therapist, qualified to work in all fields of occupational therapy, minimum of five years experience in the practice of occupational therapy, to include administrative and teaching, preferably not less than thirty years old.</p>
AUSTRALIA	<p>On Curriculum, Faculty and Facilities, the Association supports the WFOT publication: "Recommended Minimum Standards for the Education of Occupational Therapists".</p>
ICELAND	<p>At least 2 full-time occupational therapists on the faculty. Acceptable for doctors to teach anatomy, physiology, psychologists teaching psychology. There must be occupational therapists to tie it all together.</p>

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cont'd.

TABLE 6.5 cont'd.

WFOT/National Association: Recommended Faculty

WFOT/NATIONAL ASSOCIATIONS	RECOMMENDED FACULTY
U.S.A.	<p>Director shall be a registered occupational therapist with relevant occupational therapy experience in administration, teaching and direct service. In addition shall hold the masters or doctoral degree or have equivalent educational qualifications.</p> <p>Faculty shall include registered occupational therapists, qualified, knowledgeable and effective in teaching the content assigned.</p>
U.K.	<p>No requirements. Schools are inspected quinquennially by the Council For Professions Supplementary to Medicine (CPSM).</p>
CANADA	<p>Director shall be an occupational therapist, member of the Canadian Association of Occupational Therapists (CAOT), minimum of five years' practice of occupational therapy to include clinical, administrative and teaching experience and hold a masters or higher degree.</p> <p>Faculty teaching staff should be composed of well qualified occupational therapists who hold Baccalaureate or higher degrees, are members of CAOT and have had at least three years' recent experience in the practice or teaching of occupational therapy prior to appointment. Experience must have included some specialization as well as supervision and clinical instruction of occupational therapy students.</p> <p>At least one full-time secretary</p>

TABLE 6.5 cont'd.

WFOT/National Association: Recommended Faculty

WFOT/NATIONAL ASSOCIATIONS	RECOMMENDED FACULTY
JAPAN	The chief of the course must have over two years experience as an occupational therapist. Desirable he or she be over 25 years old.
GERMANY (Federal Republic)	Occupational therapists involved in training should have 5 years of previous experience.

TABLE 6.6

WFOT/National Associations: Recommended Facilities

WFOT/NATIONAL ASSOCIATIONS	RECOMMENDED FACILITIES
WFOT	<p>Should include minimum of: Two offices, one for the director with adequate space to maintain scholastic records and for students' counselling, the other for a typist/secretary. Lecture rooms and laboratories/classrooms with adequate equipment, storage space and display boards. Access to film projectors, overhead transparency projectors. A workshop which provides facilities for teaching work related activities and the construction of splint and assistive devices. Access to an open space (such as sports grounds) or a gymnasium for teaching the therapeutic use of sport and for wheelchair activities. Access to an area (or separate facilities) for teaching assessment and retraining in activities of daily living. A library for keeping books, materials and coats and a rest room. Office space for any additional teachers. Models and charts should be used to supplement lectures in anatomy and physiology. The skills or activities taught to the students will determine the type of equipment and space necessary.</p>

TABLE 6.6 cont'd.

WFOT/National Associations: Recommended Facilities

WFOT/NATIONAL ASSOCIATIONS	RECOMMENDED FACILITIES
AUSTRALIA	No statement of requirement.
U.S.A.	Physical resources requirements shall include: Classroom, laboratories, offices. Equipment and supplies consistent with programme objectives and teaching methods shall be available. A library shall be accessible.
U.K.	Schools seeking validation from the COT are required to give details of library, special accommodation and equipment available in the training programme.
CANADA	Adequate lecture, laboratory and seminar space, offices, storage, library, lockers and washrooms; heat, light, ventilation, modern equipment and teaching aids shall be provided for the educational programme.
JAPAN	Facilities must be able to provide experience in caring for a variety of types of patient e.g. variety of diseases, ages, sex, etc. etc. It is desirable that the ratio of clinical supervisors to students be one to one.
GERMANY (Federal Republic)	No statement of requirement.

least two full-time occupational therapists should be on the faculty.

Facilities/Resources

There are similarities in facilities/resources requirements from all the countries, although not as detailed as that of the WFOT (Table 6.6).

Accreditation

For accreditation, membership of the World Federation depends on a country having a professional national association of occupational therapists and a training school which fulfils the requirements of the WFOT. Accreditation of members of the profession varies from country to country as indicated in the following statements:

In Australia

The O.T. Association has no role in regard to the accreditation of members of the profession. They only have the power to refuse membership to the association.

Maiden, March 1985.

In Germany (Federal Republic)

After passing the O.T. exam at the end of 3 years in a State recognized school, there is no need for further accreditation or registration. Special registration is needed when setting up a private practice.

Thackeray, February 1985.

In the United Kingdom:

Students who are awarded the Diploma of the C.O.T. can apply for registration by the C.P.S.M; this enables them to work in the National Health Service.

Brown, May 1985.

In the U.S.A.

All occupational therapy educational programmes in this country are accredited every five years by the American Occupational Therapy Association in collaboration with the American Medical Association.

Presseller, December 1984.

In Japan

We have no role in accreditation. The Ministry of Health and Welfare makes such decisions.

Ogawa, February 1985.

6.3.2. The British Schools

The information supplied by the College of Occupational Therapists (C.O.T.) showed that there are 15 occupational therapy schools in the United Kingdom. The oldest was established in 1930 and the youngest in 1978. Of the 15 schools, 10 are in England, 1 in Wales, 3 in Scotland and 1 in Northern Ireland. Some are private schools, some are part of higher educational institutions, while some are run by the National Health Service. All the schools run a 3 year course programme leading to the

award of the Diploma of the College of Occupational Therapists (Dip.C.O.T.). All the schools are recognised by the British Association of Occupational Therapists. They are also approved by the WFOT as meeting required educational standards for training occupational therapists. Such approvals are through formal process.

All the schools replied to the questionnaire in one form or another either through letters, training schools' prospectuses and/or syllabuses. However, not all the schools answered questions on specific areas mentioned in the questionnaire. Information sent was limited in some cases because some of the schools were "in the process of completing work on a new syllabus"; "phasing out an old syllabus"; "preparing curriculum for Diploma course 1981 for submission to the College of Occupational Therapists for validation". (Diploma Course 1981 is the latest requirement of the COT for training of occupational therapists in the United Kingdom). Some schools simply stated that they did not have the time to put together the information requested.

In order to maintain anonymity in presenting the results, the schools have been coded. Each school is allocated a

Note: The College of Occupational Therapists (COT) is the education department of the British Association of Occupational Therapists and is responsible for all occupational therapy education matters in the United Kingdom.

letter of the alphabet from A to O. The summary of findings is presented in Tables 6.7 to 6.9.

Student admission and enrolment

The selection of candidates for admission to training programmes involves both the COT and the individual training schools. All applications for admission for training are made through the Occupational Therapy Training Clearing House of the COT which circulates the candidates' applications to the schools.

There is no guarantee of acceptance or even of interview for any candidate who holds the required minimum qualifications. There is considerable competition for places and selection of students for training is based on consideration of academic achievement, personality, health, motivation and any other relevant factors. The selection of students for training is the responsibility of the training establishment and its decision is final.

Handbook for Candidates, COT, page 1, para.2.

Thus the information collected and as presented in Table 6.7 shows that individual training schools have individual admission requirements and selection procedures.

Curriculum

On curriculum, information received shows that in the past occupational therapy training in the United Kingdom was

TABLE 6.7

Summary of Students' Admission Requirements for Occupational Therapy Training Schools in the U.K.

School Code	Minimum Academic Qualifications	Personal Characteristics	Minimum Age	Other Requirements	Additional Selection Procedure	Number Admitted Per Year
C	Passes in 6 GCE subjects or their equivalent, 2 or more at Advanced level to include English Language and Biology.	Friendly disposition, concern for others, willingness to learn, responsible and self-confident.	18 mature students considered	First Aid Certificate	Interview required	About 50
E	6 SCE subjects of which 3 must be of Higher grade including English. Subjects must include a Science subject and Arithmetic or Mathematics OR 6 GCE subjects, 2 at A Level. The subjects must include English, a science subject or Mathematics.	-	18 mature students considered	-	Interview required	22

TABLE 6.7 cont'd.

Summary of Students' Admission Requirements for Occupational Therapy Training Schools in the U.K.

School Code	Minimum Academic Qualifications	Personal Characteristics	Minimum Age	Other Requirements	Additional Selection Procedure	Number Admitted Per Year
G	5 GCE O Levels to include English and a science subject. A pass at 2 'A' level subjects.	Cheerful disposition, mature outlook, tact, patience, good judgement, adaptability, initiative, real interest in people, and concern for their welfare, teaching and organizing ability, imagination and determination.	18 mature students considered	First Aid Certificate	-	-
H	5 GCE O Levels to include 2 at 'A' level. To include Biology and English Language at O Level. A level Biology preferred.	As school G	18	First Aid Certificate. Medical Certificate. Visit to Occupational Therapy Department	Interview Required	-

TABLE 6.7 cont'd.

Summary of Students' Admission Requirements for Occupational Therapy Training Schools in the U.K.

School Code	Minimum Academic Qualifications	Personal Characteristics	Minimum Age	Other Requirements	Additional Selection Procedure	Number Admitted Per Year
J	5 GCE O Levels with English, a Science subject, preferably Biology. One subject at 'A' level.	-	18	First Aid Certificate. Medical Certificate. Visit to Occupational Therapy Department	Interview Required	-
K	6 GCE O Levels, 2 A levels. A pass in English Language and a science subject preferably Biology are compulsory. One of the A level subjects must be an academic subject.	Tact, good judgement, integrity, a real interest in people, ability to work as a member of the treatment team.	Under 18 not considered. Mature students considered.	First Aid Certificate	-	-
M	5 academic O Level subjects including English and a science subject preferably Biology or Human Biology and 2 A levels in academic subjects.	-	18	First Aid Certificate. Suggested visit to a Department of Occupational Therapy	Interview Required	-

influenced by its national association which developed and monitored its curriculum. The training was based upon a pre-determined set of objectives and a syllabus. In June 1980, the training pattern was changed. The COT established a system called "Diploma Course 1981".

In June 1980 approval of the Privy Council was obtained to enable:

- (a) Schools to design their own curricula according to their own strengths and philosophies around 'the Diploma Course 1981' published by the College of Occupational Therapists.
- (b) Schools, with the help of external moderators, to assess their own students.

Validation Board Manual, COT, May, 1984.

In this system, a core syllabus has been established by the COT.

As to how the schools are to use the 'Diploma Course 1981' core syllabus, there are as many ways as there are schools. Providing that a school incorporates the contents of 'Diploma Course 1981' and achieves the approval of the Validation Board, the way in which it presents the information to the students is a matter of individual choice.

Brown, May 1985.

The Validation Board approves the syllabus of individual schools and courses are internally examined and externally moderated. All the schools re-submit their courses to the COT for re-validation once every five years. Some of the schools have course committees and examination boards

which often comprise occupational therapy teaching staff, clinical staff, medical and student representatives.

It is common among the schools to have a statement of 'aims', 'general aims', and 'objectives' for individual subjects. In some of the information, objective statements, their uses and the methods of achieving them are not clear to me. Objectives are not stated as learning outcomes but rather in descriptive form. For example, statements of objectives such as:

To enable the student to assume professional responsibility using the appropriate knowledge, skills and attitudes in the planning and implementation of treatment programmes.

To help the student appreciate the need to continue the development of those personal and professional skills which are of value to a practising therapist.

There are no clear indications of the curriculum designs the schools were using; however, some schools had statements of course philosophies which were used as curriculum determinants.

The course syllabus in all the schools showed similarities and general conformity to the 'Diploma Course 1981' core syllabus of the COT. They include:

Biological Sciences - Anatomy, Physiology and Kinesiology.
 Behavioural Sciences - Psychology, Sociology.
 Medical Sciences - Medicine, Surgery, Psychiatry.
 Principles, Theory and Practice of Occupational Therapy.
 Practical skills (therapeutic media).
 Clinical practice.
 Communication and management.

Most of the schools did not give details of specific areas covered in biological, behavioural and medical science, communication and management. The contents of the occupational therapy professional courses were found to be almost the same although there were some differences in course titles. The study of occupational therapy application covered two main health areas - physical medicine and psychiatry. So did the students' clinical practice, with elective choices in community placements, for example, rehabilitation centres. The practical skills (therapeutic media) taught in the courses showed common and distinctive features. For example, the following were found common to all the schools: activities of daily living, work and craft activities, splintage, stool seating, metalwork, technical drawing, woodwork, leatherwork, printing and basketry.

The presentation of the subjects to the students was found to be arranged in sequential order. For example,

biological science subjects (anatomy, physiology) and behavioural science subjects (psychology, sociology), are taught concurrently, followed by clinical science subjects of medicine, surgery and psychiatry. Practical skills are taught concurrently with biological and behavioural sciences together with theories and principles of occupational therapy. In some schools, clinical practice is spread evenly throughout the course, whereas in other schools a larger proportion of clinical practice occurs in the last year of training.

Time allocation to various components of the course varies from school to school as indicated in Table 6.8.

The teaching methods used were varied and included lectures, seminars, tutorials, practicals, demonstrations, audio-visual aids, role-playing, group discussions. The teaching methods used depended on the subjects. For example, in anatomy, lectures, practicals and tutorials were used.

The methods and purposes of students' assessment were found to be similar in all the schools. They include continuous assessments, tests, practical demonstrations, formal examinations, teaching practical skills, assignments, essays, case study presentation and projects. Assessment was used to determine students' progression from one stage of the course to the next.

TABLE 6.8

Summary of Course Hours in Occupational Therapy Training Programmes in the U.K.

School Code	BIOLOGICAL SCIENCES		BEHAVIOURAL SCIENCES		MEDICAL SCIENCES			PRINCIPLES, THEORY AND PRACTICE OF OCCUPATIONAL THERAPY	PRACTICAL SKILLS	CLINICAL PRACTICE
	Anatomy & Physiology	Kinesiology	Psychology	Sociology	Medicine	Surgery	Psychology			
C	-	-	-	-	-	-	-	-	-	Minimum 1200 hrs.
E	125	10	100	10	94	65	75	408	341	1360 hrs.
	135		110		234					
F	172		100		220			585	500	1400
G	-	-	-	-	-	-	-	-	-	Minimum 1200 hrs.
H	250	36	190		92		50	528	344	1470
	286		190		142					
J	154		130		229			285	783	Minimum 1085
K	128		128		256			314	410	1188
M	131		84		116			768		1400
N	-	-	-	-	-	-	-	-	-	1480
O	-	-	-	-	-	-	-	-	-	1224

Source: Information in this Table is derived from individual schools' available written documents.

TABLE 6.9

Staffing Characteristics of Occupational Therapy Training
Programmes in the United Kingdom

SCHOOLS	NUMBER/TYPE OF STAFF INVOLVED IN TRAINING
C	Total of 9 5 Occupational Therapists (including Head of School) 1 Medical Doctor 3 Craft Instructors
E	Total of 19 6 Occupational Therapists (including Head of School, 5 full-time, 1 part-time) 1 Craft Instructor 1 part-time Clinical Psychologist 1 Secretary 1 part-time Clerical Officer 9 Specialist Visiting Lecturers
H	7 full-time Occupational Therapy Lecturers

All the occupational therapy lecturers have had occupational therapy teaching experience, ranging from four to fifteen years, and clinical experience of three to ten years, in a variety of occupational therapy clinical settings, including psychiatry, physical and general medicine and community services. The organization of students' clinical practices in two of the schools was found to be assigned to one specific occupational therapy lecturer. The Craft Instructors have qualifications in Art Designs, Cookery and Housecraft. Their teaching experience ranged from four to nineteen years. It is evident from the information collected that the schools use the services of specialist visiting lecturers to teach courses like anatomy, physiology, psychology, psychiatry, medicine, surgery, neurology, and orthopaedics. There was nothing to suggest the policy of staffing used by the schools nor evidence to suggest or relate the number of staff to the number of students in the training. It would be interesting to know how many students were in each of these programmes mentioned in Table 6.9. It would help to explain the numbers of staff.

Facilities/Resources

The facilities available in the schools were found to be similar. These included halls for lectures and seminar activities, large and small workshops for practical skills and accommodation of equipment and supplies, tutorial

rooms, library, activity of daily living units, comprising a kitchen, bed sitting room, bathroom, aids and appliances. Teaching and learning resources included film, slide and overhead projectors, record players, X-ray viewing boxes, 35mm and video cameras and large monitors. There was no information from any of the schools with regard to the type of occupational therapy specialist equipment available in their training programme.

Information sent suggested that more resources and facilities are available in training programmes that are part of larger higher educational institutions, compared to those that are private or run under the National Health Service. For example, programmes in larger educational institutions have the use of lecture theatres, bigger libraries, and resources of other departments within the institutions. The staff facilities usually include offices for the Principal and Secretary, individual or shared offices for the staff, and staff rooms, while the students' facilities include changing rooms with lockers, showers, toilets, wash-hand basins and common rooms. Some of the schools provide accommodation for their first year students. The second and third year students are expected to find their own accommodation. It could not be determined from the information gathered that the facilities available in the school relate to or depend on the number of students.

From the results of the studies presented in this chapter,

certain characteristics of occupational therapy training have emerged. The general conclusions in summary are that entry requirements into occupational therapy training differ from country to country. The academic requirements are based on the educational system of each individual country. Some national associations have prescribed requirements while in some countries that responsibility is left to the individual training schools. In the United Kingdom, the standard for selection of students is generally the responsibility of the national association, but final responsibility is with the schools to decide whom they want to admit. The training schools in the United Kingdom often demand more requirements (in addition to the National Association's) from prospective candidates. Thus, academic entry qualifications were found to be uniform, but some schools employed additional criteria for final selection.

The location of training varies from country to country. Some are private, some hospital-based and some are university-based. The same variety occurs in the United Kingdom but in addition some are located in higher education institutions such as polytechnics.

The length of programmes varies from country to country. The practice in Europe is for three year programmes while in North America it is four years of which students spend the first year doing general studies.

The national associations recommended staffing and facilities in terms of numbers, type and quality. The provisions available in British schools vary and to a large extent depend on the location of the school. For example, those located in higher institutions have access to more varied and to more modern resources. Since we do not have the total number of students in each school in the United Kingdom, it is difficult to establish the ratio of students to staff or students to resources. Occupational therapy programmes are headed by occupational therapists and professional courses are taught by them also. It was not uncommon to use non-occupational therapists as teachers but in non-occupational therapy courses. The system for accreditation of members of the profession varies from country to country. So too does the accreditation of training programmes.

From both studies, the curriculum contents and their distribution showed much common practice. The schools in the United Kingdom showed apparent similarities in course content and conformity to the Diploma Course 1981 core syllabus of the National Association. Some national associations are found to be very active in the training of their occupational therapists. They will give outlines of course contents and monitor the programme. They also set training standards and other requirements. However, what the information gathered from both studies did not address or was not explicit enough about was detailed

information on planning policies and procedures:
how the schools plan their courses, the curriculum design the schools subscribe to, details of course content and how they are arrived at, and the way they are structured, and details of the assessment philosophy practised by the schools.

Perhaps a study providing intimate or closer working knowledge of some of these training schools in the United Kingdom would provide answers in these areas, and this will be seen in Chapters 7 and 8, dealing with case studies of United Kingdom institutions.

CHAPTER SEVEN

THE EMPIRICAL STUDY OF SELECTED OCCUPATIONAL
THERAPY TRAINING PROGRAMMES IN THE UNITED
KINGDOM

7.1 Introduction

In chapter 5, I described the study of Nigerian occupational therapists' experiences and their views on an appropriate occupational therapy training programme for Nigeria, as part of the documentation for the overall study. In chapter 6 I also described the international documentation for the overall study; that is, the information collected from the World Federation of Occupational Therapists and occupational therapy professional national associations from different countries. In the later part of chapter 6, I also described the exploratory study of British documentation in which a questionnaire was sent to all the occupational therapy training schools in the United Kingdom seeking available information about the characteristics of their training programmes, including student admission and enrolment, curriculum plans, staffing and facilities.

The present chapter discusses the methodology adopted for the study of selected occupational therapy training programmes in the United Kingdom, the reasons for conducting the study, various aspects of procedures used in collecting the data and conducting the study and methods to be adopted in the analysis of information collected.

7.2 Reasons for Conducting the Empirical Study

The decision to conduct an empirical study of selected occupational therapy training programmes in the United Kingdom was reached on the following grounds:

The intention of this research would not be to find a programme which could be copied wholesale in developing provision in Nigeria, but rather to identify the issues which might be encountered in planning for a future situation. Some of the likely issues would be connected with:

1. The reactions of staff and students to the form and contents of teaching and learning in an existing programme.
2. The use of staff and other resources in a working programme within specific institutional contexts.
3. The nature of existing or required staff skills.

This empirical study was accepted as a useful strategy early in the study. The information collected from questionnaires to the various international and national bodies and groups was inevitably of a general nature, providing a broad framework on policies and practices. What it could not provide however was detailed knowledge of the actual workings of such policies and practices within a particular institution or insights into the dynamics of such situations. Such understanding could, it

seemed, only come from close contact over a period of time with all those involved in particular programmes.

7.3 The Research Methodology

What was required, then, was a procedure for investigation by interviews in situations in which staff and students could talk relatively openly about their work and permit the investigator to pursue matters of particular interest to himself. For these reasons, it was decided to carry out a study of two occupational therapy programmes using a case study approach.

According to Gay:

The primary purpose of a case study is to determine the factors, and relationships among the factors, which have resulted in the current behaviour or status of the subject of the study. In other words, the purpose of a case study is to determine why, not just what.

Gay (1976) page 137

Case studies would allow the investigator to employ semi-structured interviews, including follow-up discussions and also observations of what was actually happening in the course of teaching and learning. Using fairly open questioning, it would be possible to promote understanding of relationships, backgrounds and patterns of a set of events held together by their contents, structures and history.

Cohen and Manion identified a number of advantages in open-ended questions in interviews:

They are flexible; they allow the interviewer to probe so that he may go into more depth if he chooses, or clear up any misunderstandings; they enable the interviewer to test the limits of a respondent's knowledge; they encourage co-operation and help, establish rapport; and they allow the interviewer to make a truer assessment of what the respondent really believes. Open-ended situations can also result in unexpected or unanticipated answers which may suggest hitherto unthought-of-relationships or hypothesis.

Cohen and Manion (1980) page 247.

Oppenheim went further:

The interviewer can make sure that the respondent has understood the questions and the purpose of the research. We can ask the interviewers to probe further when particular responses are encountered; we can ask them to clarify the answers on the spot (field coding); they can show the respondents cards, lists or pictures, hand out product samples or self-completion checklists or diaries and make ratings or assessment of attitudes, furnishings, dwelling areas and so forth. Above all, they can build up and maintain rapport, that elusive motivating force that will keep the respondent interested and responsive to the end of the interview.

Oppenheim (1984) page 31.

The method is convenient, quick and provides confidentiality. One other main advantage of the method to the investigator is its flexibility. Given that the investigator is not experienced in the United Kingdom context, he may not find it easy to predict what questions will be useful to him to ask. Besides, one of the reasons for the case

studies is to capture local variations which are likely, and this relates especially to point (2) on page two of this chapter. The richness and spontaneity of information collected by interview procedure is higher than that which a formal questionnaire can hope to obtain. The approach would be consistent with the purpose of the study which is to gain understanding and an overview of the occupational therapy training programmes in the United Kingdom.

Furthermore, the carrying out of the case studies in the institutions would not only enable me to gain useful information from the staff and students of the institutions but would also serve the purpose whereby one could observe and learn about actual situations and other aspects of the courses. For example, what facilities are available in the training programmes, types of staff and uses of staff resources and skills; types, uses and arrangement of facilities such as space, equipment, how classes are conducted; uses of teaching aids and how staff generally go about the business of conducting occupational therapy education? It would also afford the investigator the opportunity to meet with other people who may be directly or indirectly involved in this particular programme or a similar programme.

7.4 The Interview Questions

Having stated the reasons for conducting the case studies, the writer then proceeded to formulate the interview questions for use with staff and students. In doing so, the concern was to decide on what further information to find out from the institutions about their curriculum plans, based on the information received in the preliminary study reported in chapter 6. This, and the central focus of the case studies, which was on the implementation of curriculum plans, formed the basis of the interview questions and focussed on such themes as, for example, general policies affecting the planning of courses, the processes whereby the institutions actually plan their courses, how they determine what to teach, what they teach and how it is organized in the courses, the teaching methods and evaluation procedures used within the courses. It was felt that the views of the top people in the training programmes above, that is, those who are responsible for the programmes, would be one-sided, inadequate and not provide the whole understanding needed. To support this, Shipman, in the discussion of complexities of decision-making and implementation stated:

Influences percolate up as well as down. Arbitrary changes in plans are made to fit procedures to cases that don't watch them. Policies get made and are implemented, both through improvisation and adjustments.

Shipman (1985), page 65.

Thus, two parallel sets of questions, one for the staff responsible for the design and implementation of the curriculum and another for students as recipients of the curriculum, were formulated. For the staff, the questions sought their views and experiences on course policies and procedures, working in the curriculum, the way the programme is planned, the course content and its structure, teaching methods they use and why, and assessment of students on the course. For the students, the questions centred on their views as to what and how they felt about the training they were receiving with respect to the content of the course, the way the course was structured, the teaching methods used and how they helped them (students) to learn, and how they were assessed on the course.

7.5 The Design of the Case Studies

In the questionnaire study of occupational therapy schools in the United Kingdom, reported in chapter 6, information and documentation were sought about (1) student entry requirements and selection procedures, (2) curriculum characteristics including the processes by which they are developed and monitored, objectives, contents, sequence, integration, balance, teaching methods and students assessments, (3) staff quality, type and number, and (4) nature of facilities. As mentioned in chapter 6, information was given in areas 1, 3 and 4 but was short in area 2. This then led to a sharper focussing and to concentrating more attention on the same items in area 2, but this time to include policies,

practices, procedures and responsibilities.

Arranging the case studies

In arranging the case studies, the question was, how were the schools and the interviewees to be selected? To answer this question, several possible different approaches were considered for various reasons. For example, selecting schools from as wide a variety of training settings as possible (for example from private schools, schools run by the National Health Service and schools that are part of larger or higher educational institutions), for the reasons that schools with different locations may have different methods of training, and selecting older schools was considered because it was thought they were more likely to have more experience of occupational therapy training compared to the younger schools. Schools that have had their training programme approved under Diploma Course '81 by the Validation Board of the College of Occupational Therapists were also given consideration for the reasons that they might talk about their old programmes as well as the new ones. It was also felt that the schools that sent greater amounts of information in response to the earlier questionnaires might have more information to give or be more willing to give it compared to those that sent less information. While all these were considered possible criteria in selecting schools for the case studies, they had to be rejected for reasons of problems of finance, time

and practicality. Also, while the writer was open to all these considerations, a vital question asked was, for the purpose of the investigation, does it really matter which schools are selected for the study? To the writer this did not seem to matter because all the schools are approved by both the Occupational Therapy National Association in the United Kingdom, and by the World Federation of Occupational Therapists, qualifications obtained in the United Kingdom are recognized and accepted worldwide, all of which, in one way or another reflect the quality of the training. All of the schools have been engaged for more than seven years in the training of occupational therapists which means they will all have experiences in common.

Thus, two occupational therapy schools in Scotland - The Glasgow School of Occupational Therapy and the Occupational Therapy Training Programme at the Queen Margaret College, Edinburgh, were tentatively selected for reasons of finance; nearness of the two schools to the University of Stirling, where the writer is based and conducting the research study; and the limitation of time within which the case studies and the overall research had to be completed. The selection of the two schools was tentative in that, in the event of the authorities of the schools being unwilling to allow me to conduct the study in their schools, this would then mean contacting other schools.

The selection of interviewees

The criteria for selecting who to interview in the schools selected for the study were determined by the purposes of the study, my interview questions and by my judgement as to who in the schools would be in the best position to provide information. Since the purpose of the case studies is to seek general understanding of the two training programmes, that is, what they do, how they do it and why they do it, and because my interview questions cut across different concerns and perspectives which can only be answered by different individuals or groups of individuals at different levels of the training programme, the choice was to interview in both schools, the Principals, some of the lecturers and some of the students on the course. The Principals, from an administrative point of view, would give information on certain things. Then the three groups (Principals, lecturers and students) would give information on various other matters but from their different perspectives.

Thus, the assumptions were: the Principals as the head of the training programmes would be in better positions to provide answers to questions on course policies, responsibilities and procedures; course contents and organization; teaching methods, students' assessment and course evaluation. The lecturers could give views and opinions on these same topic areas from their practical points of view, while the students as recipients of the

curriculum could give their views on the course contents, organization, teaching methods and the way they are assessed.

After deciding on who would be best placed to answer the questions, then came the method to be adopted in selecting them. There was no selection procedure followed in choosing the Principals to interview since there is only one to each school.

In selecting lecturers from both schools, the plan was to select for the interview, after discussion with the Principals of each school, three experienced occupational therapy course lecturers involved in the teaching of the occupational therapy courses and working full-time on the course; the rationale being that they are more likely to be able to give most information about the training programme and specifically my area of concern which is the curriculum plan. They are likely to be more involved in the various aspects of the course planning than, say, the psychology, sociology or anatomy lecturers who are part-time guests or visiting specialist lecturers. In addition to them having many years of occupational therapy teaching experience, the occupational therapy lecturers are also experienced occupational therapy clinicians. So, they have professional experience which they can share. However, while the procedure for the selection did not change, the actual number changed after my visit to the schools, as will be discussed later.

The choice of students to be interviewed caused some concern, which was mainly because of their number and their different stages of training. Several options were considered in selecting students for the interview. For example, asking the Principals and/or the staff to nominate students; the investigator picking the students thought or believed to be good interview material on the basis of his contact with them; and students nominating fellow students; and simply asking students to volunteer for the interview. Several choices as to which students to interview, whether first, second or third year students, were also considered. Interviewing first year students was rejected because at the time of the interview, they would have spent only about two months on the course. Although second year students would have spent one academic year on the course, it was thought the information they could give about the course would be limited and would not be as rich, compared to third year students who would have spent over two years on the course and would be in the final process of becoming occupational therapists. Thus, the decision was to select from each school, four third-year students for the interview.

The plan of the procedure for the selection was that during my first visit to the schools and having discussed my programme of activities for the case studies with the Principal, I sought their approval and permission to interview the students. I would then arrange with the Principals to meet and address the third-year students.

In the meeting, I would introduce myself, the purpose of my study, my visit to their school and the purpose of my meeting with them, which is to select some of them for the case study interview. The students would be given assurance of anonymity in the interview.

Because I would want to give each student the chance to be interviewed, I would then ask if any of the students would prefer not to be interviewed. Such students would then be allowed to leave the meeting. From those who would like to be interviewed, four would be picked by random sampling, for example, by picking a piece of paper marked 'YES' from a hat. As I said earlier, this plan was to be adopted in selecting the students. However, this procedure had to be abandoned because of the situation I found when I visited both schools to discuss my programme of activities for the case study with the Principals, as will be discussed later.

A possible programme of activities for conducting the case studies, giving details of my intended number of visits and programmes for each visit was drawn up (Table 7.1). A letter was written to the Principals of the two schools together with a letter from the investigator's supervisor to give the study plan authenticity (Appendix 7). In my letter, I reminded the Principals of my earlier correspondence, the purpose and plan of my study in Scotland and my wish to visit their schools, and a request for an appointment to see them for further discussion on the issue. Both

TABLE 7.1

Possible Programme of Activities for Case Studies in
Selected Occupational Therapy Training Programmes in Scotland

VISITS	PROGRAMME	DATE	TIME
1st	Meeting with Head of School <ul style="list-style-type: none"> - To confirm programme of activities - Discuss what documentation I could have to read - Introduction to staff 		
2nd	Interview with Head of School Meeting with 3 lecturers to discuss form of co-operation.		
3rd	Interviews with 3 occupational therapy course lecturers		1st Interview
			2nd Interview
			3rd Interview
4th	Sitting in on as wide a variety of 1st, 2nd, and 3rd year classes as possible. Meeting staff and students Looking round the school to see facilities Introduction to students.		
5th	Interviews with 4 occupational therapy 3rd year students		1st Interview
			2nd Interview
			3rd Interview
			4th Interview
6th	Meeting with Head of School		

Principals responded favourably to my letters and the first visits to each school were arranged.

The actual programme of activities during the case study

During my first visit to each school, I met with the Principals and the purposes of my study in Scotland, and my visits to their schools were reiterated. The programme of activities for the interview was discussed. The date, time and who to interview were fixed. Course plans were given to me to read and I was introduced to the staff and some of the students, and taken round the schools to see the facilities. Arrangements were also made for me to sit in on some of the classes and attend some of the staff meetings. Also, in these first meetings, I sought from the Principals, their permission to use a tape-recorder in the interviews and to mention the schools in the final write-up of the study. Permission was granted. I also assured the Principals of the anonymity of interviewees in the study and its write-up and that the study was not a critique of their schools or courses but a means of my learning about occupational therapy training programmes for the purpose of planning a Nigerian programme. The Principals were also assured that a report of my understanding of their programmes would be presented to them for comment upon completion of the case studies.

It is important to point out at this stage that it was at these first meetings with the Principals that my plans

for the selection of staff and students for the interviews had to change. Having discussed my intentions with the Principals, I found that both schools give special responsibilities to one of their staff in arranging students' clinical practice in the course, so it was decided to include these staff among those to be interviewed, bringing the number to four. The other three lecturers were chosen after consultation with the Principals, on the basis of their experience and the subjects they teach. It was also discovered that I could not carry out my original plan for the selection of students in both schools because the students were out of schools on clinical placements. Because the students are scattered all over the United Kingdom, making contact with them was rather difficult. The decision then was to locate and interview those students who were on clinical placements around the University of Stirling, notably in Stirling, Edinburgh and Glasgow. The schools contacted the students on my behalf and with the permission of the schools I also made contact with the students, their clinical supervisor and the Heads of those occupational therapy departments in which the students were doing their clinical practice, introducing myself and informing them of my plans. On the basis of the students' willingness to take part in the interviews, arrangements were made for dates and times for the interviews.

It should be pointed out that the changes in the selection procedure did not weaken the study in any way. What it did was to add to the number of staff interviewed which

was to the advantage of the study because of the special position the staff responsible for clinical practice holds in each school. The interviewing of students in their clinical placements caused extra travelling and unexpected cancelling of interview schedules due to sickness but the general arrangements did not seem to weaken the study. Indeed, it had the advantage that student selection was not directly influenced by staff or by the peer group.

7.6 The Conduct of The Case Studies

The interviews

Interview questions were constructed under the following broad headings: (i) responsibilities and procedures within the course, (ii) course contents and organization, (iii) teaching methods, and (iv) assessment/evaluation.

Responsibilities and procedures within the course

The questions concerned how the Schools go about the planning of their courses.

Principals

Who is responsible for the course? Who makes what decision(s) in the course? What prior decisions have been made and by whom? What decisions does the school have to make? How are the staff who are teaching on the course

involved in decision making? What information is used in planning the course? What are the procedures for planning the course?

Lecturers

In what way do you see yourself involved in discussions about various kinds of policies in the course? What are your perceptions of the policies for planning? How have you seen the policies translated into practice? What are your general opinions of the course?

Students

(Not relevant).

Course contents and organization

The questions concerned the kind of general decision the schools have taken and how those policies and decisions have influenced the contents and organization of the courses.

Principals

What are the policies on course contents? What are the contents of the course? What is the basis for their selection? In what order are the courses presented to the students? How are the courses related to one another in the order of presentation? What is the time

allocation to the courses and various components of the course?

Lecturers

What are your experiences of the course syllabus?

What do you see as consistency/inconsistency of what is happening in the course in relation to the course contents compared to established practice? What do you see as strengths, weaknesses, advantages and disadvantages in the course as a result of the course contents? What are your views about subject relevance, effectiveness, appropriateness and adequacy in the course? What are your experiences of the way the course is structured? What do you see as consistency/inconsistency of what is happening in the course in relation to the way the course is structured compared to established practice? What do you see as strengths, weaknesses, advantages and disadvantages in the course structure, subject relationships, and time allocation to various courses and other components of the course? To what extent are policies on course organization being realized?

Students

From your experience of the course, what are your opinions of the contents of the course? Do you find the choice of subjects appropriate? Do you find the

amount of knowledge taught in the course too detailed, adequate or too little? How relevant and useful do you find the courses? From your experience of the course, how do you find the way the courses are presented to you? Do you find the courses fit together for you to learn? Do you find the time allocation to various courses adequate?

Teaching methods

The questions concerned the kind of general decision the schools have taken and how these policies and decisions have influenced the teaching methods used in the courses.

Principals

What policies do you have on teaching methods in the course? What teaching methods do you use? What are the bases for their choice?

Lecturers

What are your experiences of the teaching methods you use on the course? What teaching methods do you use? What are your reasons for their choice? Do you use specific teaching methods for specific courses? Do you use different teaching methods at different stages of the course? To what extent are policies on teaching

methods in the course being realized? What do you see as consistency/inconsistency of what is happening in the course in relation to teaching methods as compared to the established practice? What do you see as strengths, weaknesses, advantages and disadvantages in the course as a result of the teaching methods used?

Students

How do you find the teaching methods your lecturers use in the course? Do you find the teaching methods get the points the lecturers are making across to you? How do the teaching methods help you to learn? Do you find advantages/disadvantages in the teaching methods your lecturers use?

Assessment/Evaluation

The questions concerned the kind of general decisions the schools have taken and how these policies and decisions have influenced student assessment and evaluation in the course.

Principals

(a) Students' assessments

What policies do you have on students assessment?

What methods of assessment do you use? How are the

methods determined? When in the course are the methods used? What are the amount, frequency and contents of students' assessment in the course? What philosophy of assessment do you practice (course grading and weighting; determination and processes of making up examinations for assessments; marking students' papers; interpretation of marks and consequences of assessments). For what purposes do you use assessments in the course?

(b) Course and staff evaluation

How do you evaluate the course? How are the staff teaching on the course evaluated?

Lecturers

What are your experiences of the students' assessment procedures in the course? What assessment methods do you use in your course? What are the reasons for their use? What procedures are there in the use of various assessment methods? To what extent are policies on assessment realized? What are the consistency/inconsistency of what is happening in the course in relation to assessment methods compared to the established practice? What are the strengths, weaknesses, advantages and disadvantages in the course as a result of the assessment method used? For what purpose do you see assessment in your course?

Students

What are your views of the way you are assessed in the course? What are your views of the various assessment methods your lecturers use? How do you feel about the amount of assessment and the frequency with which the assessments are conducted? How do you feel about the purposes to which assessments are put in the course?

7.7 The Interview Procedure

A total number of eighteen people, comprising the Principal, four occupational therapy lecturers and four third year students from each school, were interviewed. Interviews with the Principals and lecturers were conducted in each school respectively. The students were interviewed in the hospitals where they were doing their clinical practice.

Before the interviews commenced in each school, I studied the plan of their training programme and where possible sat in on some teaching sessions and looked into the students' assessment reports and lecturers' comments to familiarise myself in preparation for the discussion to follow.

At the beginning of each interview, each interviewee was again reminded of the reasons for the interview and the study as a whole. They were again assured of anonymity in that no name would be mentioned in the final write-up

of the study. Each interview was recorded, having obtained permission from each interviewee to do so. Most of the interviews lasted about forty-five minutes (± 10 minutes).

Having been an occupational therapy student, and now an experienced occupational therapy clinician, the writer found that starting the interview questions off with the different respondents was no problem because we would be talking the language common to the profession. However, realizing that different people often react to the same situations differently, I tried to make the first two or three minutes of each interview less formal and less threatening, then eased the conversation into the appropriate set of pre-selected questions. For instance, in the interview with the Principals we would talk first of all about our past training and work experience before the actual interview questions were introduced. The same tactics were used with the lecturers, but in addition they would tell me the areas of responsibility they have in the course, for example, what courses they teach and how long they have been teaching them. With the students, it was a case of talking generally about how they have enjoyed the course, and the area of occupational therapy specialism they would like to seek employment in after they graduated. After general discussion with each interviewee, the introduction of the interview questions would usually start with statements such as "Perhaps we could start by ..." or "I wonder if you could begin by telling me ...". I would acknowledge

the information given, to be followed by the next interview question, starting with statements such as: "I wonder if we could now talk about ..." or "I wonder if we could turn now to ..." or "could you please tell me...". At the end of each interview session I would then ask each interviewee what further information they would like to give me or talk about that we had not dealt with during the interview. Then, finally, I thanked them for the information and the time they had given me.

In each school the Principals were interviewed first, not only for diplomatic reasons but also because whatever was discussed with them might help to guide the subsequent interviews with the lecturers and the students. For example, the Principal having answered the question on course content, the lecturers and students can then give their experience and views on the same issue. Also because of the purpose of the case study, there is certain information which is required of the Principals and which can only be answered by them and not the lecturers or the students, for example, the questions relating to policies. The lecturers were interviewed next, giving me the opportunity to refer as appropriate to what the Principal had said in the earlier interview. The lecturers were interviewed individually since they taught different subjects and had different experiences of the course. The students were interviewed last. It was first thought that interviewing students in groups

would be advantageous in that where students are shy or lack self-confidence, a group interview might provide the interaction and support needed when answers to the questions were not readily forthcoming. It can create a more relaxed atmosphere and be less threatening. However, it was also possible that students would be inhibited by the presence of other students. So, it was finally decided to hold individual interviews.

Although at the beginning of the interview some of the interviewees appeared to be nervous, for example, by saying they were unsure about the type of information I wanted, with time these problems were soon overcome. The interviewees were very friendly, co-operative and receptive in answering my questions. The degree to which they volunteered information was astonishing. They were enthusiastic about my work and the fact that it was preparatory to establishing the first occupational therapy training programme in Nigeria. At the end of each interview, I was given advice and suggestions on such matters as recruitment of staff, student selection, arranging students' clinical practice, budgeting, types of facilities, and getting the training recognized by the World Federation of Occupational Therapists (WFOT). It was suggested to me by the Principals and some of the lecturers that I might wish to contact the schools for further information and advice if the need should arise, not only during my study here in Scotland, but also when I returned to Nigeria.

7.8 The Method of Analysis

In reporting the results, I have taken an open-ended approach rather than a content analysis in terms of pre-conceived ideas. The reason for this is that the case studies were concerned with understanding particular situations. They focussed broadly on what was of major concern to me. My interview questions were open and exploratory and the primary concern was with description and interpretation of views, opinions, events and experiences rather than measurement and prediction. For similar reasons it was decided not to report the materials gathered in terms of frequencies with which certain statements or problems were mentioned.

Thus, the first stage of reporting the results was to listen to and transcribe each recorded interview tape. From the volume of material gathered, it would have been an enormous task to report everything everybody said. The second stage then was one of making a personal judgement of what should be reported and how it should be reported. This I did by selecting from the materials what I found relevant to the question they answered. For example, statements that were personal, either about a particular respondent, other students, staff or the Principal, or where answers were irrelevant to questions asked, were cut out. Rather, I focussed strictly on the themes of the interview questions, and the reports were developed under the same headings.

The results of the two case studies are presented - chapter 8. The report from each school is presented separately. In each case, I take a theme (such as 'teaching method') and present separately the views of the Principal, staff and students on that theme.

CHAPTER EIGHT

THE REPORTS OF THE EMPIRICAL STUDY

8.1 Introduction

This chapter is the report of the two case studies conducted in chapter 7.

8.2 Case Study Number One

Occupational Therapy Training Programme, Glasgow School of Occupational Therapy, Glasgow, Scotland

Policies and responsibilities

The following discussion deals firstly with policies and responsibilities for the occupational therapy course at the Glasgow School of Occupational Therapy.

The Glasgow School of Occupational Therapy is run by the Greater Glasgow Health Board. The responsibility of the Board for the course is mainly to provide funding for the School. Students who are eligible for a grant (dependent on parents' financial circumstances) apply to the Awards Branch of the Scottish Education Department to cover their tuition fees and maintenance. The Principal of the school, an occupational therapist, is the administrative head of the school. She is responsible for the day to day running of the school, a responsibility given to her by the Greater Glasgow Health Board. She devises the course within the constraints and possibilities that are available to her through the resources provided

by the Greater Glasgow Health Board and the Glasgow area itself. Resources outwith the Glasgow area are also used, for example, clinical placements. Further influences upon responsibilities for and procedures in the course come from outside the School, such as the profession's national body and from the staff and students of the school itself.

The Principal stated:

There are some people who have some say in running the course, and a very vital say is the Council for Professions Supplementary to Medicine (CPSM) which is our State Registration Board and their say in the course is reflected in their quinquennial visit when they spend two days at least in the school going through and looking at everything from the actual courses themselves to the resources and staffing and the general set-up of the school.

Without their approval, the school will not be in business. It is very important we pay attention to the requirements of this Board.

The course offered at present by the school, forms part of a national system and uses a manual for diploma courses designed by the College of Occupational Therapists (COT) for all occupational therapy training programmes in the United Kingdom. Presently, the COT qualifies all students. However, the COT has recently set up a new system called 'Diploma Course '81' which all occupational therapy schools in the U.K. must adopt by 1986. In this system, the schools will present their courses for approval by a Validation Board set up jointly by the COT and the Council for Professions Supplementary to Medicine (CPSM). Once a

course has been approved, then the schools are allowed to qualify their own students, the course then being monitored by the College of Occupational Therapists, who send moderators they have appointed. The Glasgow School plans to start this new system in 1986.

In the present course, as far as clinical practice is concerned, the school has arrangements with occupational therapy clinical supervisors who come from the hospitals around the school. The staff of the school, that is the occupational therapy tutors, some of whom are on the College of Occupational Therapists' Course Planning Committee for Diploma Course '81, have a lot of say in both the present and the new course, making sure the policies and guidelines of the COT and the CPSM are translated into practice. The school has no formal planning committee, the staff is small in number and consequently all are involved in the planning process. Each is basically responsible for his or her part of the curriculum, but at the same time tutors, through meetings with one another, accept a shared responsibility for planning the whole course. As stated by the tutor responsible for clinical practice:

The way the clinical practice is organised I suppose is on a variety of policy decisions. I take everything back to the staff in the school. Yes, the structure is a policy decision and decisions with clinical supervisors and staff here. It is also laced with my vision as well. Also laced with the requirements of COT as well.

A tutor responsible for anatomy said:

Since I have been here, the programme has been changing gradually. Last year, I was asked to draw up a written document on anatomy and physiology along with other subjects. The lecturer we had at the University retired after thirty years. With this new lecturer coming, I was asked to draw up a discussion document and asked how I would like to change the course because really we are doing far too many hours of anatomy. So, we cut out a lot of things which are not essential and of course there are lots of things we don't come in contact with nowadays because of advancement in modern medicine. There is no need for us to be dealing with them. It wasn't my decision totally. It was brought up before the staff.

These comments indicate the extent to which the tutors are involved in planning the courses.

In the present course which the school is running, the COT has provided broad guidelines on what the course contents should be. The Principal, talking about the policies on course contents, said:

When the course that we are now running started, there was a manual for the diploma course on which this course which is still running was based. But, however, it has changed, adapted and grown quite a lot since the original concepts, but the concept still remains the same for the new course in that we must do the basics of anatomy, physiology, and psychology which is followed then by the medical sciences, i.e. medicine, neurology, surgery, orthopaedics and psychiatry. We have to, of course, include occupational therapy itself which is really, of course, all embracing and not only includes topics like the

actual treatment techniques, it talks about the whole planning of the treatment programme, organization of an occupational therapy department, the application of all the basic and medical sciences to the actual treatment of the patient. So, it is a pulling together in many different ways. Another factor is the decline in hours allocated to practical skills over many years.

Course planning procedure

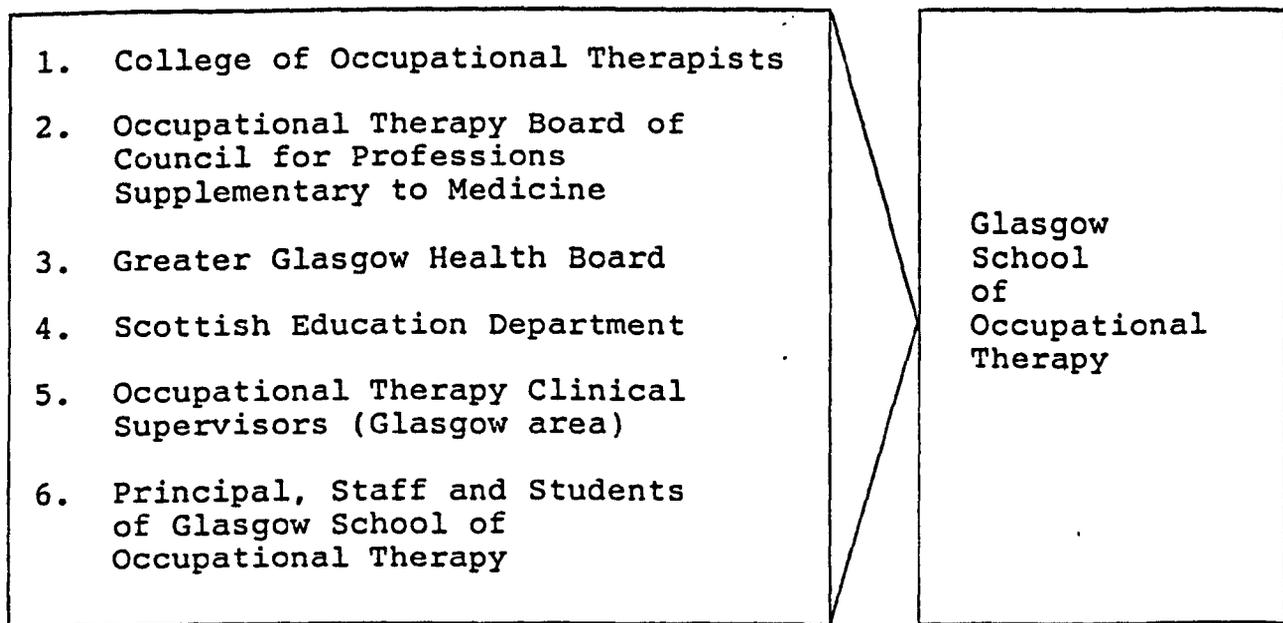
In planning the present course, the school follows the syllabus and the guidelines of the COT. But, having said that, it is then important to examine how the school has been going about the planning of its new course. The school does not use or subscribe to any explicit curriculum model. It has objectives for every course. The Principal, referring to the use of behavioural objectives in planning as compared with the starting point they have adopted in planning the course, has this to say:

That kind of method of planning (behavioural objectives) the course, we went through about twelve years ago when objectives hit us, as it were. Then, we had to sit down and work out the objectives for every course. I think as a guide to behavioural output, they are still very valuable, but I think you can get into too much detail.

Thus, the method adopted in planning the course is that the staff together will discuss what the basic occupational therapist needs, and their opinions influence greatly what the courses will include. Then they decide just

FIGURE 8.1

Influences Upon Policies and Practices in the Occupational
Therapy Diploma Training Programme, Glasgow School of
Occupational Therapy, Glasgow, Scotland.



how much of any particular subject is necessary for subsequent practice of the profession.

Considerations in selecting course content

In planning the new course, the school has decided that occupational therapy is the core of its course and will pull in the amount of anatomy, psychology, medicine surgery and so on which will be sufficient to give the therapists a basic grounding in knowledge he or she needs to practise, whether in physical or psychiatric medicine and or in the community. This is in contrast with the present course which is on the medical model and is heavy on the medical subjects of anatomy, medicine and so on.

Other considerations in selecting courses, according to the Principal, are:

In this particular area, to give you an example, this was a heavy industrial area with the docks, ship building, the mining and so on which have now run down and so consequently we don't get industrial injuries as we used to do, and with the controls of such diseases as tuberculosis, the emphasis now seems to be towards the main areas for which occupational therapy services are required, for example, the neurological conditions, the long term and the elderly, heart conditions, arthritis and fractures. Cerebro vascular accidents of course are very prevalent in this area and I think of course in most places in the U.K. This has formed a large part of the in-patient population in general hospitals that occupational therapists are concerned with. Some mental

handicaps in this part of the world and of course in the U.K. in general are now receiving more attention than they used to do and there is an awareness that much can be done for such people.

These statements mean that the changes in medicine and the type of patients that are treated by occupational therapists dictate what the emphasis is going to be in various medical and occupational therapy courses.

Course content and organization

In asking about course content and organization, it was discovered that, in the first year, students do anatomy, physiology, psychology and some sociology. They also have an introduction to their profession in general terms, that is where occupational therapists work, what roles they play. This is followed by a course in processes of planning treatment. Those are perhaps the main theoretical areas they cover in the first year. They will also have some clinical experience. Added to these are practical skills of which the main parts are in the first year and include things like woodwork, metalwork, pottery, physical education, basketry, leatherwork. The practical skills taught are chosen because of their different therapeutic uses. This year the school has introduced drama.

According to the Principal:

The reason why we have chosen that is, we found in this country lots of our young therapists are very conscious of getting up and speaking in front of other people. They are young and need practice in voice

control, in presentation of themselves,
controlling groups.

In the second year, the students are introduced to the medical sciences of medicine, neurology, surgery, orthopaedics and psychiatry. The students having done the practical skills in the first year, the occupational therapy courses will then change to application. In the second year, one is then talking of applying those skills to community occupational therapy, physical conditions and psychiatric conditions. They learn a few practical skills but the real emphasis is on occupational therapy and medical sciences. They also do some clinical practice.

In the third year, the course involves mainly clinical work. During the first term, they have a long practice of twelve weeks and then they come back into school in the spring term. The school arranges specialist lectures to concentrate on particular areas. Then they have a final practice of six weeks before their final examination. They also have to produce a project related to occupational therapy in the third year.

The tutors expressed their views about the policies for planning the present and the new course. The feelings among the tutors about the present course are that it is too rigid in content and too centralized. The COT controls the content of the course and does not give the schools the responsibility of choosing or deciding their own

course content. The professional exams are nationally and centrally conducted which forces the school to adopt a rigid timetable across the entire course. In some of the courses there were complaints of overcrowding of course content. For example, in the present anatomy course, the complaint was that there was too much time devoted to anatomy and the syllabus has been the same for many years. Compared to the present course, one gets a feeling that the Principal and the tutors consider the ideas, policies and the philosophies behind the new course 'Diploma Course '81' to be very good. Their feelings are summed up in a comment made by one of the tutors when she said:

In Diploma Course '81, which we are going to start next year, the guidelines set by the COT are fairly adequate and comprehensive and are open to interpretation of what we want to have and in validating (the course). I think in a way it is quite good that we are to have moderators and if we want something altered in the future we could make application to do so.

However, some of the tutors expressed their concern about the limitations which the new course put on their individual subjects and also explained how they have gone about tackling this problem. As one tutor in anatomy puts it:

There is one aspect of Diploma Course '81 I don't agree with. They have said the respiratory system and endocrine system are not essential. In actual fact, the respiratory system is important because of cardio-respiratory diseases. When you think of this part of the world - we have a lot of bronchitis and chest illness.

It is worth mentioning that the old course was equally prescriptive and it happened to include these topics mentioned.

In tackling this problem, the tutor gives her students the topics that the College of Occupational Therapists said are not of priority, in the form of learning packages which they research themselves and then give feedback to the rest of the class.

The tutor responsible for clinical practice has this to say about the Diploma Course '81:

In many ways from a clinical practice point of view, already we are doing much of what we will do in Diploma Course '81. I suppose one of my concerns is called Validation - the Committee that looks at Diploma '81, looks at it and (the course) is not validated for another five years, and really our clinical situation is developing quite considerably and I don't see us standing still for five years.

Again, the concern is that the course may be insufficiently flexible.

Another tutor expressed concern about the practical problems of managing the new course when she comments:

I think the Diploma Course '81 policies are very good. The philosophy behind the course is very good but I see practical problems simply because of the practical management problems of actually introducing the course. We've got a very sound philosophy in that we

have divided it up. We looked at the skills necessary to become competent basic grade occupational therapists and decided the learning could be divided into three areas; (1) management skills; (2) treatment skills and (3) behavioural and communication skills, so that each term over the three years students will have behavioural and communication modules, management modules and treatment modules. But the difficulty with that is we rely heavily on external lecturers. It is easy for a consultant to give up one hour a week to come and do a lecture. With the modular system, we are asking that bit more of external lecturers which means perhaps a longer session more often over a shorter period which the consultant may have difficulty in supplying.

The idea is fine, but I don't know whether we will be able to put it into practice as we wish because of this difficulty and constraint.

The above suggests that the school has a good plan for its new course, but for the constraints brought about by staffing. This raises the issue of the extent to which the school uses or is dependent on external staffing and the non-availability of certain facilities in the school, both of which will feature in later discussion in this case study as they pose problems for course integration and students' learning on the course.

Having talked about the policies for planning and the tutors reactions to them, it is then appropriate to discuss the views of the tutors and students about the courses, how the courses are structured, balanced and integrated.

The tutors expressed their views about the various subjects they teach and the students their views on the subjects they have to study. In anatomy, the tutor comments:

We go in depth into neuro-anatomy and neuro-physiology. That is very important because the bulk of the patients we would work with have neurological disorders, i.e. strokes, multiple sclerosis, cerebral palsy, Parkinson's disease. So we do a lot of neuro-anatomy and physiology and that leads us to neurology in the second year.

The students expressed appreciation of the importance and usefulness of the anatomy they have to learn. Students said:

Anatomy in the first year was covered very well. We learnt quite a lot. We covered everything - the muscles, their origins, insertions, nerve supply and actions.

Anatomy and physiology were fine. It was very good.

However, while all the students shared the above views, some felt the course was too detailed for what they have to know. Students' comments include:

We went into too much depth in the central nervous system.

Some of the anatomy, I felt, was quite irrelevant. We have to learn every muscle, their origins and insertions. I felt some of the anatomy we could have cut down.

During the first year we did anatomy and psychology which I felt were both very beneficial but the anatomy was rather detailed for what we have to know. Our class did individual muscles, which I don't know was that helpful.

It is important to mention here that before this case study the school had already recognized the comments made above by the students and had made changes in the subject matter of anatomy in the new course. As stated by the tutor responsible for anatomy:

We have taken away a lot of unnecessary learning, like specific details of origin, insertion of muscles. In the new course not so much (specific details of origin and insertion of muscles) because really we were doing far too many hours of anatomy. We have four hours of anatomy lectures per week plus one hour tutorial. That goes on for three terms, the first term is eleven weeks, the second term eight weeks and the third term is six weeks, a total of twenty-five weeks.

In the psychology course, students have formal meetings of two one-hour lectures per week plus a one-hour tutorial. The course is organized on two parallel lines, one following developmental psychology (from childhood to old age) and the other on social psychology which looks at groups, the way people are perceived and so on. The psychology course was described by students as "a good course", "very helpful" and "it was a good base for psychiatry".

The psychology course was followed in the second year

by psychiatry. It seems that students were not particularly concerned so much about the contents of the psychiatry course or its relevance but about the amount of time allocated to the course which was done in one term. As students commented:

The psychiatry course itself, we did all our theory before Christmas and it was finished and then we just had input from the tutors until the examinations. I feel this was a bit rushed because a lot of us found psychiatry very difficult as a subject to learn.

Another student said:

All the other subjects have been quite good except for the psychiatry being a lot crammed into one term. We did all our psychiatry in one term, two lectures a week of one hour each, then we had tutorials up to the examinations.

Another student commented:

The psychiatry was not well spaced. We did a lot towards the end of the term before the professional examinations. There were all these drugs to learn, anti-depressants, side-effects, and you know, drugs are constantly changing and I think it is quite pointless and a waste of time. I think it is o.k. to know the basics then the rest you can look up in a book.

It was difficult to establish from the students' view whether it is the time allocated to the course that makes it difficult for them to learn, or whether they found the course difficult because it is a difficult subject. While it could be argued that the time allocated to the course

is insufficient for the students to learn the subject, the view of one of the tutors supports the earlier arguments and that is that psychiatry is basically difficult to learn. She comments:

The subject matter of the psychiatry course I find extremely difficult because I am speaking about concepts, that they don't know. Like, for example, if somebody has a broken leg or arm, that is visible to the students whereas in psychiatry they find it difficult to observe the symptoms or perhaps the factors of somebody's behaviour.

The tutors and students expressed satisfaction with the way the practical skills were taught in the college, that is, the number of practical skills students have to do and when they have to do them. The students found the practical skills very useful on their clinical placements, although some of them found that not all of the practical skills taught in college were available in their clinical placements. In college, at the end of every practical skill, the students had activity analysis forms to fill out. They also have to compile a folder for each practical skill to contain things like what type of patients they will use the skill for, how they felt when they were practising the skill, what sort of movement they had to use and how hard they had to concentrate. The only criticism of the activity analysis by one of the students is not of the principle behind it but of the forms they have to fill out. As the student said:

We had to do activity analysis and the forms we used were really long and drawn out. They were about six pages long. I know you've got to be able to analyse an activity but the difficulty is just the forms they use.

The same student made comments about some practical skills, for example, physical education, cookery and design, when she said:

I felt the design course was a waste of time because all we were doing was painting and stuff like that. We could have had one hour's lecture on it rather than doing about five weeks of it.

I didn't think the cookery was very good because it was just everyday we went in we were just cooking something and it wasn't applied to occupational therapy or anything like that. So I felt that was a waste of time as well. If it had been applied to occupational therapy like the use of a wheelchair in the kitchen and so on, it would have been more beneficial.

Another course we did was physical education. That I felt was irrelevant. I didn't really gain anything from that at all.

These concerns about particular practical skills were expressed by one student, it was difficult to know whether other students share her views since they did not mention them. But they did mention the fact that they found practical skills very useful and enjoyable.

A lot of changes are being made. According to the Principal:

Activity analysis form - this is being altered considerably. Cookery, design and physical education have also been reviewed and will be very different in the new course.

One of the points raised earlier in this case study concerned the facilities available in the school and the effect these may have on student learning. For example, one of the students raised an important point about the equipment she had to work with in her clinical placement which was not available in the school, and she said:

I would like to have had in college some of the machines and equipment found in clinical placements. Like other schools have got all these machines in their colleges. The students have a chance to try out the machines before they go out into clinical practice and they get a chance to try out aids. We don't have the opportunities at our college to try out things and experience the use of aids. I think that is quite a good point because I was lost during my first week in the heavy workshop in my clinical placement. I didn't have a clue about the machines, which patients to use them on and how they work. Whereas students from other schools know the machines inside and out.

The Principal mentioned that:

Machines and equipment are available in local departments and students are at liberty to arrange an opportunity to learn about them with the head of these departments. Expensive equipment being idle most of the year is a waste of money.

The students felt satisfied with the courses in occupational therapy applied to physical and psychiatric conditions and also felt the courses could have been covered in more depth in some areas like cerebro-vascular accidents (CVA) and community occupational therapy.

In the clinical practice, students do about twelve hundred hours throughout the three years and it is divided into blocks of five placements. In the first year, students have two placements, four weeks in January of the first year and six weeks at the end of the first year. These are very much concerned with communication and observation skills. They then, in the second year, have one eight-week placement right in the middle, that is, the spring term of the second year. Then they go on to the third year where they have three months at the beginning and six weeks at the end, just before they graduate. According to the tutor responsible for clinical practice:

This is a four phase programme based on good educational principles. You start with observation, then working with the patients, (then) on to phase three with a degree of independence, and phase four really is a basic grade level where they are evaluating and modifying appropriately with increasingly less support.

Both the tutors and the students expressed satisfaction with the present clinical practice arrangements in the course. The tutors feel that doing clinical practice in blocks is quite sound as far as learning is concerned. One tutor in support of the present clinical practice arrangement said:

At one time we had all the clinical practice at the end of the course. I think this was bad for various reasons. First, a student could come here and cope with the academic work and get to the third year and find she couldn't cope with patients. They were learning subjects with no knowledge of what they are like in reality. They can pass examinations. So you try to explain what it is like to have delusions and hallucinations, our students just had no idea what that was like. They have never seen it before. They couldn't really perceive it. It was extremely difficult for them to understand what effects the illnesses may have on these persons' ability to cope with their lives. So we changed the whole thing and spread the clinical practice throughout the three years. The thinking behind this is that you gave them information that will help them in the areas of skills. Now, if you are going to be a therapist, you can not do anything about treatment planning until you can interact with patients. So at the beginning of the course, we try to give the students skills, understanding and so on geared towards that end in the first placement. We are really asking for that kind of thing to make sure they get plenty of practice. Then you are building up knowledge, you gear it towards the next practice.

The students feel because of the way the clinical practice is organised in the course that they can see relationships in their learning, relate theory to practice and, coming back to school after each practice for more learning, improve on what they have learned in hospitals. Thus, students comment as follows:

It has been sequential. I think the way our clinical practice is spaced out gives you some time to think about what you've done on your placement and (then) do some more theoretical work before you go out again. I think you need plenty of time in between. You learn an awful lot in your placement and you need time to sort things out when you finish.

Another student said:

I like them in blocks. For example, in your first placement, there is not much you can do. You can only observe, you can not really become that much involved. You have only had a few months training by the time you go out for your first placement. But it is nice to see what an occupational therapist does so close to when you come in (the course) because it reinforces what you have learnt and what you've been told about occupational therapy.

While the way the clinical practice was spaced was considered very reasonable by the students, some students expressed the problems and difficulties they have to face when they are sent to placements they felt they had not been properly prepared for by the school. For example, one student said:

I found that my second placement, which was at the end of the first year, was a psychiatric placement and I found it really quite difficult because I have not done any psychiatry at all. I found it very threatening. I found I really wasn't prepared for that. I was lost. I didn't know what I was doing at all. I would have liked to have done some psychiatry before going into psychiatry placement.

Another student, commenting on the psychiatry placement, said:

When I was in first year, I went for my psychiatry placement. We haven't done any psychiatry. We don't do psychiatry until second year. I was on the placement and I knew nothing of psychiatry, and I found it very difficult because the occupational therapists would talk about conditions and they expected me to know about it. Of course I didn't. I think the first year placement needs to be organized more carefully, not to send students on placements they have not covered the work for because it is just confusing to a first year student to be thrown into a situation like that.

It is not only the psychiatry course that is not covered before students go on clinical practice. A student on neurology placement said:

My second placement was in neurology and we have not done neurology. We have done the basic neuro-anatomy but we haven't done any conditions. It was just worthless. It didn't mean anything to me. So, I found it difficult. It didn't really prepare me for the placement. You could teach practical skills to patients and you don't really know why you are doing it.

In contrast to what these two students said, it is interesting to hear a student who has done some psychiatry learning before going into psychiatry placement say:

This is my first psychiatry placement. So I have done my psychiatry learning. So that is very helpful. A lot of students had psychiatry placements in second year and they have not done psychiatry, so they found it very difficult in the placement. It was quite easy for me to relate back to the course.

So it seems there are advantages and disadvantages in this type of clinical placement arrangement. While it draws students closer to the clinical practice situation, the lack of knowledge as identified by the students to make appreciable contribution in the clinical situation more or less defeats the purpose of the clinical work. The present arrangement does not seem to guarantee every student adequate and appropriate knowledge for the task of the clinical placement to which they are sent early in the programme. While it could be argued that students who have learnt psychiatry or any clinical science subject in school before going into clinical placement would find it easier to understand placement experiences by relating these to the preceding course, on the other hand, students who had a placement before studying the related course could be expected to make sense of the course by relating it to patients they had encountered.

However, it does seem that the purpose of sequence and integration in the course would be defeated if students were not made to see relationships between theory and practice.

But according to the Principal:

One of the constraints in planning the Psychiatry course was the availability of consultant psychiatrists and the timing of the second year clinical placement in the spring term. An introduction to psychiatry and neurology will be included in the new course before the second placement.

The tutors and the students hold the view that it is a balanced course as far as time allocation to various components of the course is concerned. The Principal stated:

In our programme there is approximately 700 taught hours of theory, just under 500 hours of taught practical skills and 1200 hours of clinical practice. To this should be added another 300-400 hours of student centred learning both in and out of college. The World Federation of Occupational Therapists' Guidelines were laid down many years ago as a basis for school curricula. You will find, as we all find, that resources in your school are contributory factors, you will have enthusiastic lecturers in their subjects which you will try to curtail and you will have to discourage subject experts from going too much into detail. For instance in medicine, we are down to about 22 hours of lectures and similarly in surgery and psychiatry 28 hours. The important thing is we have control of the contents of all subjects as we see it necessary for the occupational therapist.

Although students made some specific criticisms about specific courses, they seem to accept and have expressed satisfaction with, the general structure in that they did anatomy, physiology, psychology and some practicals in the first year followed by medicine, surgery, neurology, orthopaedics, psychiatry and applied occupational therapy in the second year. The comments of three of the students are as follows:

I think it is done in the right order.
I think psychology is good to lead on to psychiatry because you have got some understanding of the way the mind works before you go into psychiatry.

I think the sequencing was fine. The anatomy gives you the background for clinical sciences.

We did anatomy first before we did the medicine and surgery which I found very reasonable. It was handy for neurology as well because we did neuro-anatomy in the first year. When we did things like cerebro-vascular accidents (CVA) and applied occupational therapy, I found myself going back to what I learnt in neuro-anatomy. Looking back on it, I don't think the course could have been organized in any other way. I think it was quite relevant to have done anatomy and psychology first, followed by psychiatry, medicine and surgery.

While the students were talking of the course structure, the tutors were more concerned about integration of various areas of knowledge the students receive within the course. Although they agreed that the course structure,

balance and sequence were good, as they are at present, their concern is not of students getting too much or too little of theory, practical skills and clinical practice or more of one than the other. Rather, this concern is more in the way that the course is structured which doesn't make the best use of all the material or knowledge the students learn simultaneously.

The tutors feel the courses could be integrated more than they are. As one of the tutors said:

Integration in the course at the moment is not good. I personally do not think the relationship is good. Each part of the learning tends to be in compartments and students do not link one piece of learning to the next. For example, they would come to the first class of applied psychiatry from first year. They start psychiatry in second year and I then will start talking about basic principles of learning in psychology which is the basis of a psychiatry course and they all stare at me - oh! - we have finished our professional exam in psychology. They are told of the link but in the past it hasn't been handled well enough. The integration has not happened enough for them to see it. This is the first year because of the discussion of 'Diploma '81' and with the modular system that it will no longer be the case. There will be definite links throughout the whole training. I will really like to see the integration happen more between the physical sciences and the psychiatric sciences. For example, presenting a hypothetical case to students in which the patient presents physical and psychological problems and the students then have to deal with it. As it is now, if it is not designated as occupational therapy

physical or psychiatry, the students don't think in that way. They are into compartments of physical and psychiatry disabilities. In one of the psychiatry exam papers dysathria came up. Students couldn't understand why dysathria was in a psychiatry paper.

Another tutor commented:

One of the weaknesses in the course, I think sometimes because of the nature of learning, we put things into compartments. Sometimes we forget things have to be intermingled. As an occupational therapist, you can not have things in compartments, everything has got to be intermingled because people are not in compartments.

Another tutor said:

At one time, I was doing tutoring in psychology, psychiatry and occupational therapy applied to psychiatry and I found this very useful because I could integrate the three subjects. I knew what the students had in one course. I would bring it out in the next course and build on it. I found it very stimulating. This to me is a good way to do things.

The three comments present different arguments as possible reasons for lack of integration in the course. One, that the learning is in compartments, two, that the teaching is not co-ordinated - different people teaching different related subjects. It seems also there are other factors which may be contributory to the lack of integration in the course when one of the tutors mentioned:

I think that I have always felt we needed to integrate the courses much more and the constraints that we have because we make use of external institutions like the university. This cuts down our ability to be flexible in some ways. It makes time-table planning very difficult. I think this is one of the reasons - when I first came we had a very rigid time-table.

Teaching Methods

But how about the teaching methods used in the course and what constraints do they have on the course? The Principal, referring to this, said:

This again depends on the subjects and perhaps the facilities we have available. The methods are being dictated really by the national exams in that we have to give a practising method that is applied nationally. One of the constraints and it is an awful constraint is that really, although we have a 9-5 day, five days a week, which is roughly thirty-five hours, education practice dictates that really twenty hours is more than enough of staff-student contact in a week and I think we are running at the moment at about twenty-two. In the new course, I am trying to keep it down to eighteen hours. What we are trying to do in the new course is to introduce far more student-centred learning than we presently do and directed study, so that there is not so much face to face contact between the teacher and the students because we feel this is a better way of learning and is the modern trend.

The school has no prescriptive policies on teaching methods to be used in the course, rather, individual lecturers

and tutors use whatever method they feel is appropriate for their subjects. As stated by one of the tutors:

There are no policies on teaching methods to use. I just use the best method I can think of. The actual individual teaching is solely up to the individual tutors.

The school employs the services of specialist lecturers to teach the medical and behavioural sciences of anatomy, physiology, kinesiology, psychology, medicine, surgery, orthopaedics and psychiatry. While the specialist lecturers do straight lectures in their subjects, the occupational therapy tutors do tutorials in these courses to tie it down to the profession. They also teach the occupational therapy courses of practical skills, occupational therapy applications to health conditions, management, etc., etc.

As it is in the school, the teaching methods used in the teaching of various subjects include formal lectures, tutorial sessions, sometimes, it is a discussion round a topic, practical sessions and the use of film and video. For occupational therapy courses, according to the Principal:

We use all kinds of methods to teach that. We may do some straight teaching of factual matters but more than likely we would involve the students quite quickly in setting the problems, dividing them up in small groups to work at it, bringing them back to discuss it. The ideas are then shared and very often if they thought around it, they can work out what will be the appropriate treatment.

This gives them a great sense of knowing the subject. We do a lot of student involvement, perhaps it may be in the form of incomplete handouts and as the lesson goes through the students will complete the handouts from what is discussed. They are given assignments to do and perhaps asked to bring back information to the next class. They may be sent out to do some actual surveys if it is appropriate. For instance, access to buildings. Things like this we would use. They certainly do imitation of disabilities. I would say we use a variety of teaching methods such as are suitable to the topics being discussed, but most of them away from the straight lecture type situation; that is getting less and less.

The use of different teaching methods in the course by the tutors is consistent with what the Principal said above, as the tutors talked about the methods they use in their courses. Also the students go for lectures in some subjects in one of the universities near the college.

The tutor responsible for anatomy tutorials said:

At the university it is a straightforward lecture. The practical session involves the use of various specimens and students work in groups. In tutorials, to start off, I introduce some topics. I introduce some question sessions, work in small groups of two or three, and give feedback to the rest of the class. The students like the tutorials and the discussion that follows because they can help each other out.

A tutor in psychology said:

We have formal lectures. In the tutorial sessions we do various things. Sometimes it is discussion round a topic, sometimes I do practical exercise, i.e. decision-making in a group, sometimes a film followed by discussion. Sometimes I give them a choice of assignments.

The tutor who is responsible for both the management course and occupational therapy applied to psychiatry conditions said:

I use as much student-centred learning as possible. I would use small groups, some individual projects, some lectures, splitting students into small groups for half an hour and then feedback. I may design a hypothetical problem and they will then have to develop a solution to the problem. The philosophy of this is based on learning theory, the more somebody has to think out the skills or processes of their learning, the more able they would be to remember.

The school considers the involvement of students in their training to be very important and therefore involves the students in the teaching and learning processes throughout the course. Consequently, relatively little use is made of lectures. This use of student-centred learning and directed study are because of a concern felt by the school, as reflected in the comments made by the Principal of the school, when she said:

We certainly encourage the students to go and find materials at the end of every session by giving them references in our library so that they can go and look into things in more depth appropriately. We certainly, in practical skills, encourage students to teach each other because our students come straight from the rather rigid educational system in Scotland. They just sit back and expect us to teach them a lot. They have got to break that habit as much as anything because if a therapist can not be self-directed towards learning, he will not make a very good therapist, so we sort of train them at the same time.

How do the students view the teaching methods? How do the teaching methods help them to learn? From talking to the students, their views seem to suggest they like the tutorials, the group teaching, discussions and practical sessions, as illustrated in their comments:

We had lectures in psychology followed by tutorials and we work quite a lot in groups which is quite good. We went to the Southern General Hospital for lectures and then we went on ward rounds with the neurologist. That was very interesting because we can see the conditions we have been told about in lectures. That was very good. It was a back-up to what we have learnt in lectures. I found that very useful.

Another student commented:

The occupational therapy applied to physical condition was very good. Sometimes our tutors ask us to do group work. The problem is when you do group work many of us students don't take it seriously because we feel it is an unnatural situation. Some of the discussion groups are very good.

Another student said:

I like the use of the overhead projectors and the handouts are very handy to have for you to refer to. The group discussion I found to be very good. You learn from other students' experiences as well. I like the practicals used for anatomy. It is a lot easier to learn what you are taught and what you see. The handouts for the occupational therapy applied make learning easier, followed by case study and we divide into groups. You get ideas from everybody else.

However, not all students find groupwork a good method of teaching and learning. One student said:

When it is group discussion, that is very difficult to take notes and learn because you are getting different information. I prefer lectures. Lectures can be very good as well. I like lectures because you know the information you are getting is right. I take my notes during the lectures and it is my easiest way of learning.

It is interesting to compare the comments of the last two students, the first revealing a desire to participate actively in the learning process, the other demonstrating a totally passive approach.

The tutorials given by the occupational therapy tutor after specialist lectures are highly favoured by all the students. The students' views are summed up in a comment made by one of them when she said:

After the lectures, we have tutorials in college by one of the occupational therapy tutors, which I think is very helpful because we can bring up what we want in tutorial and the tutor would go over it. Like, for psychiatry, we had one lecturer who was a bit difficult to follow. So, it was quite handy to know that we could take it to somebody to go over it again. It was quite mixed though. We did get quite a lot of information from the tutors as well, but we were encouraged to look up information ourselves. The way the lectures were, you have to very quickly write things down. I found myself a lot, going home at night and having to look it up again, just to make sure I had everything.

However, not all teaching methods used by the tutors are favoured by the students. One of the students commented on the use of video-taped group work as a teaching method in a course on interviewing.

Her comments could also be related to or seen in the light of the comments made by another student earlier on, in that some students don't take group work very seriously. Referring to the use of video equipment, the student said:

What we had to do was (that) one of us had to pretend she was an occupational therapist and another one a patient. We had to go on the video and the rest of the class were watching next door. It was terrible, because nobody was natural. This went on twice a week for six weeks. I didn't find it beneficial. You are just not natural in front of a camera, especially when you know somebody is watching you next door.

The arrangement whereby courses have to be done away from the school, the use of specialist lecturers to do the lecturing and occupational therapists to do tutoring are policy decisions of the school for reasons of non-availability of certain teaching facilities and staff within the school itself. Students expressed some concern, not about the use of lectures as a teaching method but rather because of the use of specialist lecturers from elsewhere. This relates to the attitudes of some of these lecturers and the way they conducted their lectures and to the inadequate time allocated to some of the subjects. Two students on the course made the following comments:

We had outside lecturers for most of our subjects. They just lecture. Some of them are better than others. Some simply read the lecture notes and walk out and that is their job done. Some of them didn't even give us the chance to ask questions. Like, for example, our psychiatry lecturer, he actually works in this hospital (the hospital where the student is currently doing her clinical practice). As it turns out, he is totally against occupational therapy and he doesn't refer patients to occupational therapy at all.

Another student, commenting on the psychology lecturer and the time in which they had to do the lectures, said:

We used to get one theory lecture every week. I felt it was too long. The lecturer didn't really make it interesting. I don't just speak for myself but speak for a lot of other students. We felt it would have been better to have two, one-

hour lectures than two hours all at once because you have to take in a lot of information in these two hours. It was difficult.

Evaluation

In the present course, the policy of the COT on assessment is that students are examined nationally and centrally. This, however, has some constraints and influence on the course, as explained by the Principal in her comments:

I have to be honest in saying the courses we teach are influenced by the national exams. They have to learn the facts of the particular science but they also need to know what to do with these facts. So this is going to be the great change in the new course from the old, which concentrated very much on factual recall and exams. We have felt the course did not prepare students for working as therapists, enabling students to pass the exams, and nothing more.

Time allocation to various components of the course is not as we would like because we are bound by the date set for the national exams, which is a constraint.

For some years now, the school has had a situation where continuous assessment carried out in the school can add to the mark achieved at the end of the course exam. The way this is done, according to the Principal, is that:

The subject lecturers will draw up exam papers which they will do in consultation with the tutors and myself. We have objectives for all the courses so we easily see whether they are on target and so on. Sometimes what the subject lecturer sees as important, we don't see as important.

The lecturer who in psychology for instance sets the end of term exam will mark the papers. The tutors will also set some essay assignments and mark those. The marks obtained by each student are added up at the end of the year, weighted and given a value of so many units. Maybe there are five or six types of assessment, all with their marks, which are then converted to represent thirty percent of the total one hundred percent which will be given to the exam. The students may carry something like twenty out of thirty points with them into the national exam.

Students are examined internally on every practical skill they learn in school and they have to compile a folder on every one of them.

The clinical practice assessment is based on accumulated clinical practice reports which come from the clinical supervisors. Each student must pass his/her clinical placement. If not he or she would be asked to do another one.

In the present course, basically, the national system puts forward end of course exams in which students are

nationally and centrally examined in each of the main topic areas of anatomy, physiology, psychology, medicine, surgery, psychiatry, applied occupational therapy, and so on. The process whereby the national exams are made up and marked, according to the Principal, is that:

With the final papers that are nationally examined, I am one of the final national examiners. Three of us, one from each school, put our heads together to devise the papers. We have to produce three papers together with marking guides. These papers are then forwarded to an external assessor in that subject who is appointed by the COT. He/she will approve or disapprove of the papers. Then there is the Examination Standing Group in Scotland which actually is responsible for these exams. Early in the year we have what is called a paper-setting meeting in which the exam papers are presented to the Committee (ESGS) and discussed and will be altered to ensure there is no ambiguity in the actual questions. And then these papers are actually held by the COT prior to the exams. The people who get the papers will mark them and again we have at least two people marking the papers, plus the external assessor because she will look at the marks that both examiners have given to a particular paper and if they agree, well and good. If they don't they will come to an agreement. The marking guide helps tremendously.

The students' marks are interpreted as follows, based on a five-point scale:

A = 75% and over

B = 65% - 74%

C = 50% - 64%

D = 45% - 49%

E = Below 44%

A mark of D is considered a borderline pass and students who score D can be discussed further. A Principal who has a student with 49% can demand further discussion with the Exam Standing Group on that mark.

A mark of E is a failure and can not be discussed. At the moment the present examination system is very straightforward in that, if a student fails the exam, he/she is allowed only one resit. If he/she fails the resit, he/she is automatically out of the course.

The school has no formal policy on assessment methods to use in their continuous assessment but there are certain things that have been laid down like the formal end of term tests which have been accepted over the years. The assessment methods are determined largely by the national exam methods in that the school has to give the students appropriate experience in the assessment techniques that are applied nationally. The end of term tests are usually in the form of essays and the writing of short answer notes. The students have assignments, tests during the term and study of a group as part of their continuous

assessment. These methods of course depend on individual tutors and lecturers and the subject they teach.

There are different views about the use and benefit of various assessment methods used in the course. The Principal, expressing dissatisfaction with the present national assessment method which concentrated on essay-type questions, said:

I think we would prefer to think of alternative ways of assessing anatomy for instance which at present requires straightforward recall. That in my view is not testing. Any smart student will just say 'I don't have to be there or attend classes for as long as I can just read it and pass the exam'. But, the next year, they have forgotten it and they tend also to regard anatomy as first year stuff and they don't need to remember it and so want to get away from it.

Another tutor, commenting on the use of essay questions, said:

In the past I have tried essay-type questions. The problem I found with those was that it was very difficult to get questions that were not stereotyped. The assignments make students draw on their own experience. They have to think more and apply what they learn.

However, another tutor, holding a different view and expressing preference for the use of essays, has this to say:

I think continuous assessment is the best way to assess in anatomy. In an essay, you are able to put it down in a coherent, logical fashion and to let people know that you know what you are talking about. I am not in favour of this open book learning, or doing an essay at home, because, from experience, knowing students, essays given to students to be done at home often end up with somebody doing it for the students.

The students did not comment on the individual methods of assessment used in the course, nor did they argue for or against any of them. Their thinking was not on the same line as their Principal and tutors. Their general opinion is that assessments are necessary and desirable in the course. Their arguments in support of the use of assessments in the course are as indicated in the following comments:

Assessments are very important, they indicate what you know and what you don't know, and what you have learnt.

Assessments are necessary to find out how you are progressing, to give you an idea of where you need to pull up, what you need to work on. I think the assessment is necessary but it does make you feel threatened at times.

The students find continuous assessment very useful and to their advantage and are in favour of it. The students' comments are that:

It helps you towards the final mark because if you do well in the school tests, it is to your advantage.

Another student comments:

I think it is a good idea. The exams we did in college made up thirty per cent of the whole mark because if you have done well throughout the year, it will give you good grounds for going into the professional exams.

Here, the students emphasise two separate points:

it let's you know how you are getting on; and it is a bank balance which you've got in store when you go into the national exams.

However, one student did raise a point about the way the school handles the continuous assessment when she said:

In the first year, we were not actually told that these tests we sat at the middle and end of term will count towards our final exam marks at the end of the year. We found this out from students from the previous year. I mean you would have tried more if you knew it would count towards your professional exams.

This is interesting because according to the Principal:

Students are lent a handbook of information before commencing the course which details how the continuous assessment operates.

There is one area of the assessment that the students were very vocal about and that was the total amount of assessment they have to do in the course. Although

not all the students shared this view, the majority feeling was that there was too much assessment in the course. One student said:

I think there were too many exams. They gave little tests all the time. I found there were far too many exams. A term lasts only about eight to ten weeks and you have middle of term exams, end of term exams and tests in between. You always have exams coming up. By the time you get to the professional exam, you are sick of exams. When it came to the professional exams, everybody was shattered. They just couldn't be bothered. It wasn't just me, it was the whole year. The whole year was depressed in the second year and in fact there were about five or six girls that gave up the course because they found it too much. From October to December we would probably have three or four exams in one subject and with four subjects, it was very tough.

Another student said:

I think we get far too many assessments. In one term we did about fourteen tests. Some of them are short-answer questions like in neurology, essays and multiple-choice in medicine, short notes in psychiatry and written tests in applied occupational therapy.

Another student had the following comments to make:

In the assessments we did get feelings we were being watched all the time. They use exams. We had assignments in first year for psychology and class tests for every subject and obviously the exams at the end for every subject. In the second year we got rather a lot of class tests. I think it was nine we had in the space of three weeks which didn't include the professional exams. So the assessment did get on top of you after a while. It was just one test after another.

One of the students did not share the view that assessment in the course was too great, but expressed a different concern which the other students did not mention. This was concerning the time at which tests were done in the course.

The amount of assessment in the course is probably about right. Exam-wise and tests, I think that's fine. I think in the first year you do need a lot of tests and assignments to make sure you are learning your anatomy. Because if you lack in your anatomy you can get left behind and it is very difficult to catch up again. I think the tests were good because they make you work all the time. Sometimes they gave you tests two or three weeks before the final exams which I don't think was good because you've got your exams to sort out and how you are going to revise.

One further aspect of the course which was discussed concerned the assessment of the course itself. Comment here came from the Principapl, who said:

This is done at the end of the academic year when we have what we call the planning period in which we go through all the courses we have taught in the previous year and evaluate them in terms of whether we feel they were successful or whether there is room for improvement, need addition or something should be left out.

In this arrangement, once a year the staff have a "forward planning meeting" where all the tutors meet, go through each course and discuss both the students' opinions of the courses and the students' performances, and anybody

is "free to chip in ideas". With the new course, the staff are meeting far more regularly than they ever did with the present course in that they are designing something new for validation by the COT.

The Principal mentioned that she does not have formal responsibility for assessing her staff. According to her:

A formal assessment and rating of all staff in the National Health Service is long overdue.

8.3 Case Study Number Two

Occupational Therapy Training Programme, Queen Margaret College, Edinburgh, Scotland

The present occupational therapy training programme in Edinburgh was formerly provided in the Occupational Therapy Training Centre in the Astley Ainslie Hospital, a National Health Service Hospital. In 1979, the facility was transferred and became a department within a larger educational institution in Edinburgh, Queen Margaret College, (QMC).

Policies and responsibilities

Under this section of the case study, the discussion will focus on the policies underlying the course and the influence they have on the responsibilities of individuals and groups of individuals who organize and teach the programme.

The Department of Occupational Therapy at Queen Margaret College (QMC) is not running the Diploma Course '81 of the College of Occupational Therapists, but, according to the Head of Department:

We are running still the diploma course that has been running for a number of years in Edinburgh. It is the old diploma course, we have just taken our last intake into that course and it must be phased out. All over the country, the old diploma courses have to be replaced either with Diploma '81 which is the new scheme for the diploma of the College of Occupational Therapists (COT) or by a degree, if it is possible to have it validated by the Council for National Accreditation Award (CNAA) or by Universities. We are submitting to the Council for National Academic Awards for a proposed three-year programme leading to a Bachelor of Science degree in Occupational Therapy. We hope to be able to start it in 1986.

There are many people or bodies who have some say in both the present course the Department is running and the degree course currently under planning (Figures 8.2 and 8.3).

FIGURE 8.2

Influences Upon Policies and Practices in the Occupational Therapy Diploma Training Programme, Queen Margaret College, (QMC), Edinburgh, Scotland.

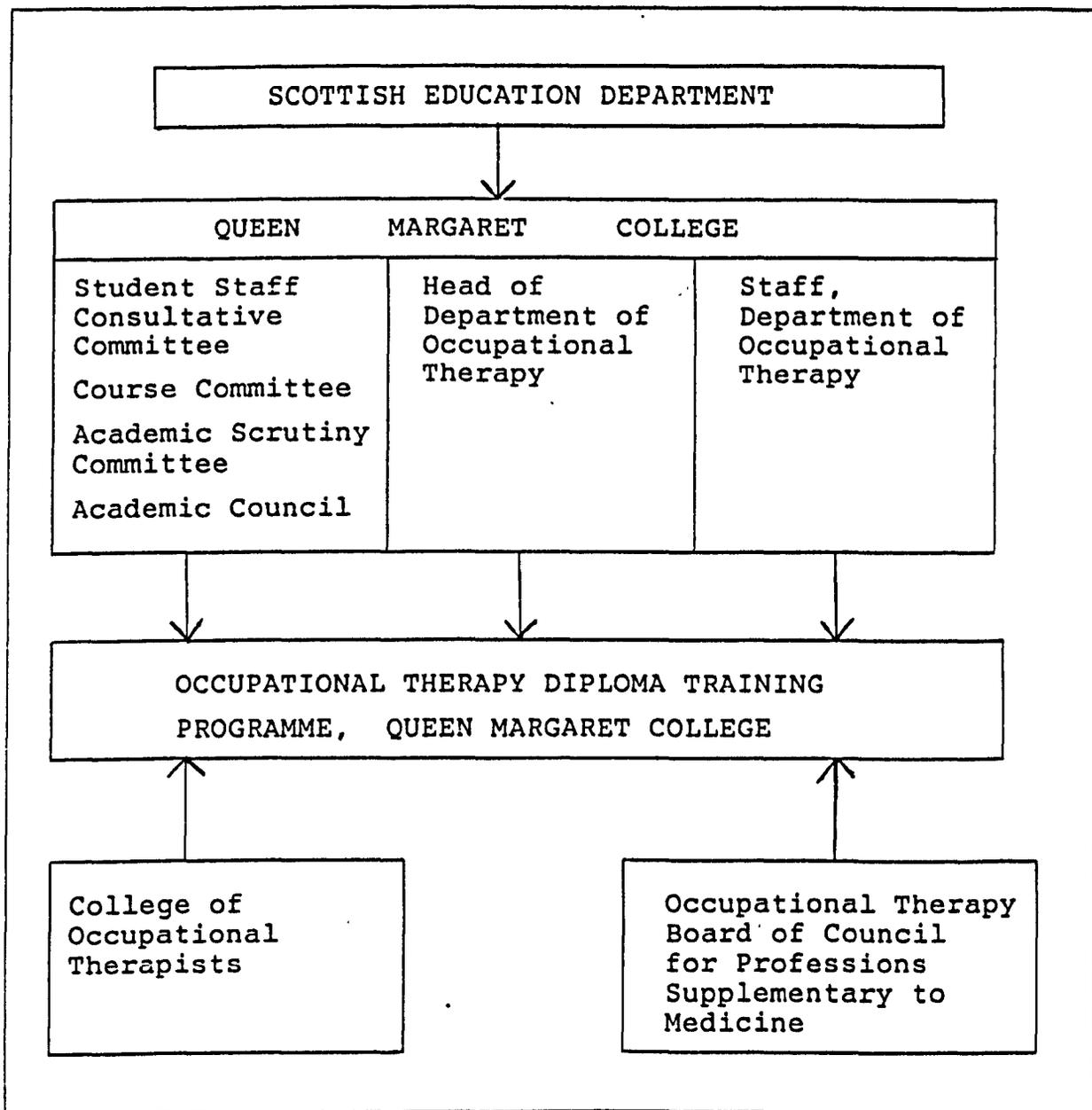
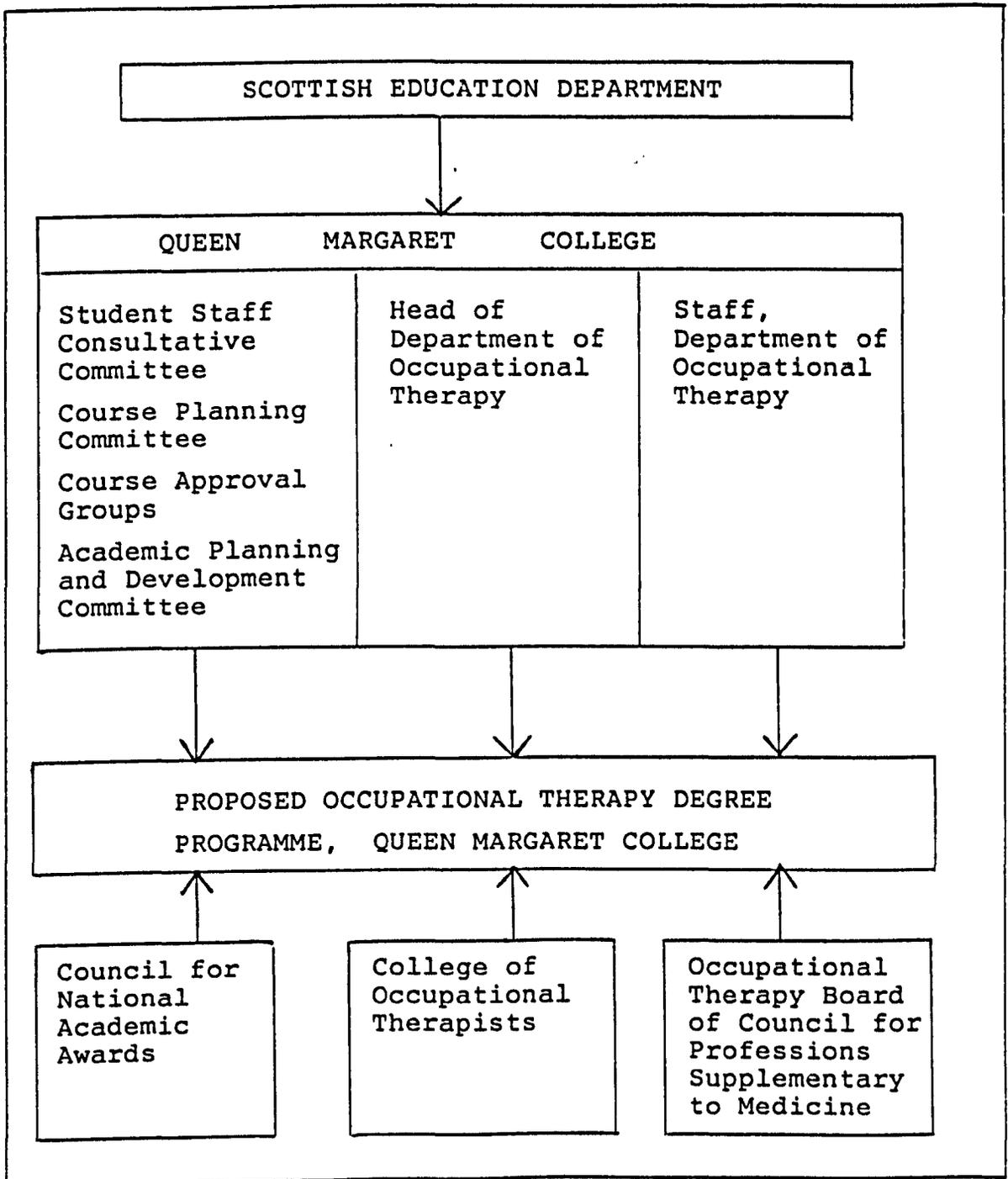


FIGURE 8.3

Influences Upon Policies and Practices in the Proposed Occupational Therapy Degree Training Programme, Queen Margaret College (QMC), Edinburgh, Scotland.



The College of Occupational Therapists has some major influence on the present course in that the course leads to the award of the Diploma of the College of Occupational Therapists. According to the Head of the Department:

The present diploma course was basically planned many years ago to meet a rather flexible outline syllabus that was compiled by the Board of Studies of the Scottish Association of Occupational Therapists. When the two Associations - the Scottish and the English Associations - merged in 1974 to become the British Association of Occupational Therapists, agreement was reached that Scotland would continue to run the diploma courses according to the Scottish pattern, preparing the students for the Scottish examination which would be approved for the award of the Diploma of the College of Occupational Therapists. So, in fact, since 1974 we have had two separate national examination systems - one for Scotland and one for England and Wales, both preparing students for the same Diploma of the College of Occupational therapists.

In this arrangement, students are externally examined by the College of Occupational Therapists. Each school's interpretation of the syllabus has to be approved by the Occupational Therapists Board of the Council for Professions Supplementary to Medicine and the College of Occupational Therapists. The Department in Queen Margaret College, like any other occupational therapy training programme in the United Kingdom, has to teach the course according to the approved course document. The Council for Professions Supplementary to Medicine and the College of Occupational Therapists

monitor the contents of the course and the educational provision of the training programme through a joint visit every five years. The training schools may only make minor changes to the course contents or structure. If they wish to make major changes, they have to apply to the Occupational Therapy Board of the Council for Professions Supplementary to Medicine, for approval to do so.

Although the Department is submitting for a degree course to the Council for National Academic Awards and not Diploma '81 of the College of Occupational Therapists, it still has to pay attention to the guidelines and requirements of both bodies. According to one of the tutors:

We have to take the Council for National Academic Awards' Guidelines but we've got to put the two together because obviously our degree has got to meet the College of Occupational Therapists requirements and also the Council for National Academic Awards.

Within the College itself, responsibilities and procedures in the course are rather complex. For example, the College is centrally funded by the Government, so its top layer of authority is the Scottish Education Department which provides funding and also approves the policies and management of the College.

The College, of course, has requirements which the Department must meet. According to the Head of Department:

We must use the College's administrative structure. Every course in the College has a course committee on which there are representatives of this Department and other departments that teach on the course, and student representatives. We also have a Student/Staff Consultative Committee where there are more students than there are staff. This is to give the students opportunity to suggest ideas for the course, to discuss how the course is going, in other words to make known their points of view. Minutes from that Committee go to the Course Committee. From the Course Committee minutes are sent to the Academic Scrutiny Committee of the College which reports to the Academic Council for the conduct of the course. This is why I think the strength of being in an educational establishment is tremendous, because you've got this important academic support.

The Head of the Department, an occupational therapist, has managerial and academic responsibilities within the College. She is responsible for the administration of the Department and of the course. She is also the academic head of the teaching team because she is the Chairman of the Course Planning Committee. But having said that, decision-making is not concentrated in one person or the Head of Department, but rather, it is democratic. For example, according to the Head of the Department:

If the Academic Scrutiny Committee wants attention paid to something, or if, for example, the students don't like the way a course is taught, I wouldn't, as head of department, make a change. I would take it to the Course Committee and the Course Committee would decide how to handle it.

Although if it is anything to do with the actual course itself, decisions are not really made by the department but by the Course Committee, the department does have a certain amount of influence as a department and as professionals. For example, the department is responsible for the selection of students into the course because it is a professional course.

The plan of the present course was inherited by the staff of the department. So, they were not involved in its planning although they plan their own teaching programme to meet requirements as set out in the syllabus. In the planning of the degree course, the staff are much involved and satisfied with their degree of involvement. The staff made the following comments in support of their involvement in planning the degree course.

We are changing course at the moment. We are all very involved in the actual planning for the new course - the degree course. I feel I have been quite involved, particularly in the planning of the occupational therapy applied side of the course. There has always been two or three of us doing the planning, not just one person.

We have all been very actively involved. I don't feel out of it at all. It's been a very democratic process of change that we've gone through. There has never been any autocratic decision. We have all very much sat down to discuss who is doing what, who is going to plan what. Personally, I have been involved in two aspects of the planning of the new course. One is the psychiatry input and how that is going to be taught and what

that is going to involve and the psychology. Also, I was on a small working party. Four of us designed the whole of the occupational therapy input for the whole course. So, I was quite actively involved in it, doing quite a lot of the planning. I helped develop the occupational structure of it.

I have been very much involved in the planning of the degree course as other members of staff have been in this department. We work as a fairly democratic team towards pooling ideas.

Course planning procedure

As stated before, the course the department is running now was planned many years ago and was inherited by the present staff: This means the staff were not in a position to discuss the concerns, information and procedures used in the planning of the course.

Considerations in selecting course content

In planning the degree course, the head of the department stated:

We reckoned we were preparing students to work at least nationally (UK), some of them internationally. so we didn't look only at local problems, but tried to make a good, general, overall programme geared to meet the needs of the United Kingdom (not the Third World).

What the department has done in planning the degree, then, is to make use of the results produced by a working party of the College of Occupational Therapists who did a survey

of the areas of disability or groups of disorders in which occupational therapists are working most. From this, a clear indication of the major areas of occupational therapy practice emerged. This the department used in planning the balance of the degree course. The head of the department went further:

For example, in physical areas, occupational therapists spend a lot of their time working with patients with neurological difficulties. So, we've put greater emphasis on that, than there is on other areas. Another thing we did was to send a questionnaire to our clinical colleagues, all the people who take students on the diploma course for clinical practice, asking them what they saw as areas of strengths and weaknesses in the present diploma course. In other words, asking them what we should keep or discard and where they thought practice was going to go in the next ten years. We got quite a lot of useful information that way.

Having got all this information, what the staff then did in planning the course, according to the head of department, was:

We decided, as a group here, that what we wanted to do was to look at the end result and say 'this is what we would like people to know, would like people to be able to do at the end of the course. They must be competent occupational therapists and in order to be that, they must know this and that. They must also be able to do this and that'. We worked backwards and planned the course to meet that end.

One of the tutors interviewed, elaborating on the above, said:

The planning involved how the occupational therapy course would evolve throughout the three years of training, looking at links through clinical practice, pulling together the two main strands of physical and psychiatric occupational therapy and how we can integrate that into a total programme. We tried to look for the common denominators. It's really looking at progression through from first year, what a first year student would be or should be capable of on a very basic level in terms of the skills of approaching patients.

From these comments, it is evident that the department did not plan or base its degree course on any formal curriculum model. The use of behavioural objectives as a method of curriculum planning was mentioned to the head of the department. Her comments indicated some of the perceived weaknesses in the use of behavioural objectives as a curriculum planning tool:

I think we've passed through a fashion stage. There was a time when behavioural objectives were very fashionable and everybody wanted you to write behavioural objectives. I think we've grown out of that and passed through it now. One has, rather, course aims. A behavioural objective has to be very, very carefully written. I think to write aims for a course, yes; I think to write objectives, sure; but to make them all behavioural objectives is false. I think you can get yourself into the most appalling tangle if you try to write everything in terms of behavioural objectives. You've got to come down to such minute details and there are so many words you certainly can not use in behavioural objectives. Some things are just not measurable, not in these terms.

Course content and organization

My access to the degree course plan was limited because the degree course at the time of this study was still at the planning stage. It is therefore important to point out that the discussions that follow on course content, the way the course is structured, time allocation to various components of the course, along with the discussions of the views and opinions of staff and students on some areas, are about the present diploma course which is soon to be phased out, and that where possible in the discussion the proposed changes are discussed along with the existing situation in the present course.

The proposed diploma course follows the medical model in that in the first year of the course, students start on the basic sciences. In other words, students do anatomy, physiology and psychology in the first year. Some theory of occupational therapy in simple terms, like activity analysis, the history and development of the occupational therapy profession and professional structure; a lot of craft work, for example, weaving, basketry, woodwork, stool seating, macrame, design, and collage. All these are done in the first year and the idea according to the head of the department is that:

First students learn the normal working of mind and body and they learn a range of practical skills (craft skills) which they learn and analyse, not in medical terms but simply in terms of what the activity demands of the individual.

Then in second year, students learn about the abnormal mind and body. They do psychiatry, medical conditions, and surgical conditions. The occupational therapy courses become much more focussed in that students can then apply the practical skills that they learned in their first year as therapeutic activities. By this time, too, students would have done very little clinical practice.

In the third year of the course the students are applying all the things they have learned in the practical situation and spend the whole year in different clinical placements. The clinical experience is divided into four major blocks in the third year. This means in the third year the students are away from the college. The thinking behind this, when that course was arranged, according to the head of the department was:

You learn the normal, you learn the activities and you analyse them. You learn the abnormal, you apply the activities therapeutically and then you go out and do it in the field. That is the system I inherited.

The present course arrangement has changed radically in the degree programme plan. The department has been very careful to integrate clinical experience with academic learning and with learning experiences. Consequently, the degree course has been planned so that students alternate between college work and clinical work. Right from the beginning of the course they do twenty weeks of college work first of all and then they have a four week

block of practice. They return for college work and at the end of the first year they have another block of practice of five weeks. In the second year of the course there are two blocks of clinical practice, four weeks in the middle and five weeks at the end of the year and in the third year of the course, there are two six week blocks of clinical experience. So it is integrated all the way through the degree course as the clinical practice will be discussed later.

The staff, talking generally about the course contents, see the general advantages as preparing students well for the clinical practice. According to one of the staff:

I think the occupational therapy subjects we do here are well taught and they prepare the students well. The big strength is we are very academic. We have good lecturing input in terms of learning acquisition. I think the occupational therapy subjects are fairly well covered.

However, the general consensus among the staff is that the present course is too overcrowded. As mentioned by two of the staff:

I could probably criticise the past syllabus quite a lot in that I think there are too many bits of things. I mean if you look at the present course, the present second year timetable, there are about eighteen occupational therapy subjects that we teach. I think that needs to be rationalized. I think that kind of syllabus is wrong. There are too many bits.

My initial reaction to the whole course was that there was a vast amount the course was actually doing. It's a very packed programme.

This view was also shared by the head of the department when she said:

It is a very overcrowded syllabus, we have made such changes as have been possible to make to improve the course in recent years, but it is so overcrowded that really the only way to make it a better course is to re-write it completely and this is why we have planned a new course and we have chosen to go for a degree. But having said that, we still managed to turn out diplomates who are quite highly regarded and competent occupational therapists.

Some of the staff spoke about some of the subjects being taught in too much detail, plus the lack of relevance in some of the subjects. For example, the staff in their comments, said:

A lot of the basic sciences I think are taught in too great a depth for our students. It is not necessary to know the physiology of the cells or whatever. I think this is also true on things like, for instance, surgery. We do quite a bit on general surgical materials, like ulceration, hernia, etc., conditions occupational therapists don't treat. Certainly they might see they should have a little knowledge of them, but we spend too much time looking at things that have minor relevance to occupational therapy. To a certain extent we have taken care of this in our submission for the degree course.

The wastage of information was quite phenomenal. I sometimes wonder and it can only be a wonder, about some of the physical courses like bio-mechanics, kinesiology and whether we do need so much of them and I have never practised in these areas, so it is not fair to comment on them.

The consensus among the students is that most of the academic courses taught in the course are relevant to the practice of occupational therapy. According to them:

I think everything that is included is relevant.

Majority of the courses are very relevant - anatomy, physiology, psychology, psychiatry.

Most of the courses I found relevant. I would say the knowledge on the theory side is deep enough. In general, I think the programme is very good. We cover a lot of things within it.

I considered the courses relevant.

However, one student talked about some of the academic subjects and shared the view of one of the tutors, discussed earlier, as to how deep some of the academic subjects were taught, when she commented:

The medicine and surgery were very worthwhile but I think we go into anatomy and physiology far too deeply. I mean we could do as much as medical students. Again, the sociology was sort of airy-fairy. The medical conditions we studied were more worthwhile because you are actually meeting the patients who have medical problems. They are very realistic to do.

While the staff were concerned with the course being overcrowded, students talked about additional subjects they would have liked to have in the course. The students felt they should have done courses in first-aid and counselling. Their concerns and reasons for the inclusion of these subjects in the course, as seen by two of the students, are as stated in the following comments:

I would say one thing which our course misses out which I and more or less the whole year feel is very important is general first-aid because we do no first-aid at all. When you are in this type of profession, people expect you to know something about first-aid and we are taught nothing about it at all.

Instead of art and design, I would have liked something like first-aid. If you are responsible for a patient in a department and something happens, people expect you to know what to do. I think everybody should get a course in basic first-aid instead of something like art design.

One of the students, commenting on the importance of including a course in counselling, said:

Right now we are having some hassling because we wish we had done some counselling. Because it is very intimidating. I am twenty years old, trying to help somebody who is eighty and dying. They may want to talk about serious problems and we've been given no guidelines as to how you can deal with these type of problems.

Two students expressed their feelings about other aspects of the course, for example, the academic and the occupational therapy courses and course relationships, when they said:

Academic subjects are easier to learn than occupational therapy subjects. Occupational therapy subjects are subject to different interpretation.

A lot of the courses, we couldn't see the relationship. Things that didn't fit. I mean, we did a course in mechanics and then kinesiology. Nobody appreciated their significance and if only they could explain why we were doing it, because they are useful for such and such. They don't do enough of joining everything up where it all fits into the role of a therapist.

Students do a wide range of practical skills in the course. The justification for these by one of the tutors is that:

People need a range of practical skills. They need to know enough about them so that they can use them. The trend recently has been to employ occupational therapy helpers quite a lot and they carry out lots of practical activities. So your occupational therapists become managers in that context, but that is no excuse for not knowing how to do things yourself.

The staff seem to be unanimous in support of the way the academic subjects are structured in the course. Their comments are:

I like the way we work from the normal things like normal psychology, anatomy, physiology, so that students in first year learn what is normal and then they can begin to learn what happens when things go wrong with the normal process. They learn abnormal processes like medicine, surgery and psychiatry. It follows logically.

Personally, I quite like the idea of first year being a grounding in psychological and anatomical sciences and the medical sciences applied on the top of that in succession.

However, one thing mentioned by one of the staff which according to her, she is not too happy about, is:

Most of the practical subjects are in first year and they (students) don't have enough occupational therapy subjects in first year.

The students are also in support of the way the theory and the academic subjects are organized in the course. Their comments are:

The order we did the courses - anatomy, physiology, psychology and practical skills in the first year and medicine, surgery and psychiatry in second year, I would say are very reasonable and helped you to learn.

Learning anatomy first helped me to learn orthopaedics. Seeing it in theory in anatomy relates more. We did anatomy then general surgery and orthopaedics and we found the sequence very good.

I like the way they organize the courses in our college. At the time we didn't feel the theory courses were very well put together because you've got anatomy and physiology in first year. Then we've got medicine and surgery in second year. The subjects of first year prepared us for second year. At the time when we were actually doing them, I couldn't see the relevance of learning about muscles to occupational therapy but later you come to realize how important they are in occupational therapy.

The main criticism of the structure of the present diploma course by the staff is that the clinical practice occurs primarily in the third year of the training. In the course, students only have six weeks of placement at the end of first year, none in second year and then they are out on placement for the whole of the third year.

According to the head of the department:

This is one of the things we don't like about the present diploma course in that there are six weeks of clinical practice at the end of first year, and all the rest of the clinical experiences are in the third year of the course. So, virtually, the third year students are away from the college far more than in it because they have four major blocks of clinical experiences in the third year.

The staff also shared this view and two of them, in their comments, said:

In the present course, I think the thing that is wrong is the distribution of clinical practice being in the third year. I think the students need to be out on clinical practice more evenly through the three years rather than most of it in third year.

Of the way the courses are structured, with the exception of clinical practice predominantly in the third year, I think the structure is quite reasonable from normal to abnormal, from personal skills to more group involvement.

However, students have mixed opinions about the arrangement of clinical practice in the present course. While some support the view of the staff that the present arrangement is inadequate, others feel the arrangement is quite good. For example, two of the students, arguing in favour of the present clinical practice arrangement, said:

I would say it is quite a good idea, the way our course is organized. You are doing all your main block practice once you have done all your theory. Then you can put theory into practice.

I think the way our course is structured is good as far as clinical practice is concerned. We are in college for the first two years and out in the third year which is good because now we know all the theory and we just put it into practice.

Two other students who are against the present structure of clinical practice in the course argued that:

In first year we have one week orientation of clinical practice which is just far too soon because we are in college for just five weeks. I mean we know nothing. Then you are out again at the end of first year and nothing again till third year. It doesn't build up your confidence. If you are actually learning medicine, you go out on clinical placement as you are learning it, it will be a lot more relevant than in third year when you have forgotten your medicine. You are totally out of college and from your tutors, to go out and ask.

I think two years in college is quite a long time and the clinical practice could have been spread out better. You go to the next placement when you are just settling down to one placement. I found it very difficult to change from one to another and you don't get a break in between the practice. You finish on a placement on Thursday, have an examination the following day, the following Monday you report at your new placement. It is awful. The clinical practice could have been spread out more, especially, you could have one placement in second year.

An important point raised by one of the students concerned the issue of how adequately students are prepared before going on clinical placement and whether the clinical practice could have been arranged to coincide with the knowledge the students have received before going on placements. For instance, a student expressing problems which students encountered in this type of arrangement said:

We get absolutely no psychiatry before the end of first year. We did psychology but anything like basic patient handling was related to physical, and then, when we went out on placement at the end of first year, not all the students could go to physical placements. Some had to go to psychiatry without any course in psychiatry at all. Even those of us who went to physical placement then, didn't have enough of medicine or surgery. It was all very vague to us when we went on placement.

The balance of time allocation to the various components of the course, that is the theory, practical skills and clinical practice, vary. While no specific total of hours for each specific component was given, the head of department agreed that the World Federation of Occupational Therapists' guide of time allocation of one-third theory, one-third practical skills and one-third clinical practice in any occupational therapy course, is very useful and a good plan to work to. She went further to describe the unbalanced nature of the present diploma course and the circumstances that led to it:

Our diploma course, in fact, has become unbalanced over the years and we now have more hours of clinical practice than we have of college work. Circumstances have caused that, partly the length of terms has changed since we moved into education and the length of the working day has changed a little and this has had an effect on the hours of the course. In the new course, we have planned less clinical studies hours, but it is still over a thousand hours.

The staff agreed that the World Federation of Occupational Therapists' guide was very good but they felt it is often very difficult to relate time allocation to theory and practical skills when, for instance, one is teaching a practical skill along with the theory behind the use of that particular practical skill in occupational therapy.

The staff agreed that the time allocated to academic subjects and to occupational therapy in the present course is good as it is. They also agreed, however, that too

much time is spent on practical skills in the present course. Their comments are:

I think we devote too much time to practical skills at the moment, just purely teaching them the acquisition of skills.

In our course, we probably have too much on the practical aspect.

I think sometimes one might question the amount of time they spent on woodwork. I believe it is very relevant and I try to make the students think as positively as possible about it. I believe in moderation and a range of skills for practising occupational therapy.

The students' only comment about the present course shares the staff view that too much time is spent on practical skills, especially woodwork, as their comments suggest:

I just feel far too much time is spent on crafts and when you go on placements, you don't see most of these crafts used. I think it is good to realize what potential there is for their use but I think too much time is spent on crafts in our course. I mean we did two years of woodwork which was far too much.

I think there is too much emphasis given to craft work, woodwork especially. Because you find in big hospitals where you are working, there are all the technicians who do that type of thing. Fair enough - you need to know the theory to be able to apply it to the patient situation, but we spent two years doing woodwork at college.

I could see you may have to do three or four practical skills but we did something like ten.

There is quite an emphasis on crafts in first year. Something I would say is overemphasized. I personally haven't used all that much of it in placements. It does allow you to assess different activities better but I would say, things like woodwork - for the depth we did it - any department that is going to use it to that depth would more than likely have a technician. I think it was too detailed.

As far as integration is concerned in the present course, one of the staff said:

One problem on this course has been with the integration between different aspects of occupational therapy. You don't necessarily know quite what somebody else has been teaching. Sometimes things get changed and not everybody knows about it and that might be relevant to what you are teaching. Sometimes we have a problem in terms of knowing what other people are doing and that is because we don't really have a course co-ordinator.

Teaching methods

The discussion that follows focussed on teaching arrangements within the course, and the teaching methods used, along with the views and opinions of the staff and students on these issues.

There is no policy on teaching methods in the course. The teaching staff decide on their own methods of teaching and ways of presenting their materials to the students.

According to the head of the department:

Nobody lays down any way that teaching should be done except that there is a structure in that there are a certain number of lectures and tutorials in each topic. But the way in which these are dealt with is up to the teachers. If they want to tutor by having a discussion group or asking the students to prepare materials, fine, as long as the material is covered.

One of the advantages to the course as far as teaching is concerned is the location of the department within a larger educational institution whereby the department has access to a variety of teaching resources. One of the tutors said:

I think we have got a good range of teaching methods. We are particularly lucky in the situation we are in, in that we have a whole lot of methods like video and all that kind of thing that we can use. We are lucky because of the facilities we have.

The staff of the department who are all occupational therapists teach on the course as well as staff from other departments within the College and visiting specialist lecturers from outside the College.

The occupational therapy staff teach all the occupational therapy courses on practical skills and occupational therapy applied to health conditions. In all the

academic subjects of anatomy, physiology, surgery, psychology and psychiatry, lectures are given by the non-occupational therapy staff. These lectures are supported by tutorials given by the occupational therapy staff to smaller groups of students. Students are split into three groups for tutorial purposes so that, for example, in a course like psychiatric conditions, the students would have an hour's lecture from a visiting psychiatrist in the week, and tutorials from occupational therapy staff who are knowledgeable about psychiatry.

There is quite a range of criticism by both the departmental staff (occupational therapy tutors) and the students about the lectures given by non-occupational therapy staff. The feeling of one of the tutors is that some of the lecturers go into too much detail in their subjects without actually giving considerations as to how useful the knowledge they are giving will be to the student. As she stated:

Some of the courses are not taught by occupational therapists. The problem sometimes is in the perception of the person teaching it. The anatomy and physiology is a classic one, I suppose. That is the one I know there's quite a lot of problems with because the person teaching it tends to put too much emphasis on the subject, compared to maybe what the students actually need to know to be a professional occupational therapist. That type of thing can become a problem and it can happen in any subject. People tend to do their

own specialty without really looking at the needs of the people they are teaching. We have a system, say, with the academic input, where psychologists for instance do the lectures and we do the tutorials. Now that works very well to date. At first we used to sit in on the lectures just to get what the lecturer was saying, to make sure our tutorials were relevant and now that we are familiar with the contents, we don't sit in on the lectures. So we just take the tutorials, pick up the topics and make them relevant to the occupational therapy situation.

Another problem in the lecturing system, seen by another occupational therapy tutor, is that students sometimes don't seem to see the relevance of some courses when they are taught by non-occupational therapy staff. She referred to a recreation course:

Which last year was taught by another member of the college; not by an occupational therapist. This was found to be unsatisfactory. It's a fairly interactive course. It's highly relevant to their practice as occupational therapists not only using group activities but learning how you can modify them, adapt them, learning how they can work together in a small group. But it does depend on who is teaching it because the students did not find the relevance last year when it was taught by a non-occupational therapist.

The preference of staff for the use of tutorials by the occupational therapy tutors also seems to relate to the problems in the lecture system, as one of the tutors explained:

The tutorial system allows for a lot of interaction. I think there are some weaknesses in the lecture system which has to draw on lecturers from other departments who are not always of most help with the needs of occupational therapy.

The students' concerns were about the attitude of some of the lecturers and the problems the students encounter in understanding what some of the lecturers are teaching.

The students' comments, for example, are:

The lecturers (non occupational therapy lecturers) seemed to be concerned about putting their hours in and not interested in whether students learn or not.

The lecturers maybe (are like this) because they are specialists in these areas. Sometimes you find it difficult to understand exactly what they are trying to get over. Whereas, the tutors explain it in much more simple language. I really think if the tutors hadn't been doing that, the students would be in trouble.

With these comments from the students, one could see how students' learning in the course could be affected.

The staff teaching on the course use a variety of teaching methods. The visiting lecturers and the staff from other departments of the college teaching on the course mostly use lectures. The occupational therapy tutors use lectures only to a very small extent.

The tutors gave the impression that they tend not to use lectures a lot in their teaching but only as a means of putting information across and 'not just standing up in front of students and talking non-stop'. The attitude of the tutors to the use of lectures could be summed up in the comment made by one of the tutors, when she said:

I think it is too easy for the students. They take notes and nothing really sinks in. The number of points you can get across in one hour is very limited. One of the problems of lectures is students just come and they expect to be told stuff. They don't expect to ask questions or think about situations and I don't think that is very helpful. Lectures are very passive in that students just sit and listen and make notes. It doesn't motivate students to take part.

Thus, the tutors, in the tutorials, tend to use workshops, groups, seminars, demonstrations, discussions and students are taken out on visits to various places. They also use resource packages in the form of prepared tapes, slides and video programmes which were found to be very useful, especially since the department does not have ready access to patients for teaching purposes since they moved into the College. Although it was found common among the tutors to use various group participatory teaching methods, even so, this depended on individual tutors and the course being taught. This is highlighted in the following comments made by the tutors:

I tend to use small groups. I like to get student involvement in the course. For instance in the psychology tutorial you can divide them into small groups and get them to discuss things in detail and use, sort of, snowballing techniques. Splintmaking for instance is very practical and you get the class on assignments. They know they have to make five splints with certain types of features, demonstrate that they can handle the materials, know the names and so on. We also look at the application and the kinds of disabilities you will use them for. We do a course in the second year that deals with the study of work. A number of factory visits are arranged for students. Students have to observe somebody at work and write up a report on that. The other visits later in the course involve going to sheltered workshops or educational places where handicapped people go. So there is a lot of involvement with the community and we have people coming to speak on the course, i.e. the Disablement Resettlement Officers (DRO).

I like the problem-solving approach personally. I don't like standing in front of students and saying 'this is the answer'. I like students to be involved in problem-solving and I expect participation from them. So, group discussion, I do a lot of role playing. I use a lot of dramatic techniques because I teach drama. I have been developing quite a lot of video to supplement my teaching. One of the things particularly in psychiatry is that we try to get the students to communicate because when they go out as occupational therapists, they have to be able to communicate. So, we encourage them to do presentation, to talk in front of their group, to contribute to discussion. Because, if they do it here they find it easier when they go out on clinical practice and ultimately when they practise as occupational therapists. So, we encourage a lot of interactional skills.

In tutorials and discussions, work in small groups and pairs provides shared experience. Discussion is important and I found it useful and was comfortable with it. I use these methods because they suit me but it also depends on what I am teaching. If I was teaching social skills training, I would be doing a lot of role playing and interaction. In craft classes, I teach a student and I expect that student to teach others. We also use that approach in recreation so that they all get practice in teaching on the grounds that if they can teach each other they should be able to teach patients. I like them doing as much as possible for themselves.

I personally operate best on some sort of dialogue going between me and the class. and I can manage that even in a large group. The assignments which we set them, those which are related to researching information and producing an essay within a limited range of choices are a very good way of learning. It doesn't direct the students through the same route, and I think in psychiatry in particular, where it is impossible to say 'this is right, that is wrong', we have tried but not very successfully as yet, to get away from the formal lectures because with a pure lecture from a psychiatrist, the students tend to think this is a gospel, and if one is trying to widen their horizon, the reading is one way of helping to channel their interests into different ways.

The arrangement whereby the lectures are carried over into tutorials by the occupational therapy tutors is highly favoured by the students. The students considered the tutorial methods to be quite good and very helpful in their learning. The following comments by the students suggest they learn more and better in the tutorials than in the lectures and also indicate how the various methods help them to learn:

The lectures were given by outside lecturers and the tutorials by members of staff in our department. My experience, and I think a lot of people felt the same, was in actual fact, you gained more from the tutorials than you did from lectures. Most of them use demonstrations and models which I think, the visual aspect of it does help a lot. In tutorials in anatomy, for instance, after the lectures, the tutor would focus in on what she thought is important and more relevant, use models. The other thing we tend to do is very often they get you to do the work instead, rather than writing it up on the blackboard which I would say is a very good way of learning. I mean you don't enjoy it very much at the time, you get a muscle, stand up and tell the rest of the group what the muscle is, where it came from, what the nerve supply is. I don't think many people like this method at the time but psychologically it makes you learn. The psychology tutorials helped to clarify what the lecturer was trying to go over.

Those who used demonstrations were good. They caught people's interest, whereas somebody who stood and talked for three hours, half of us fell asleep. When something is demonstrated, I found it easier to learn. The medicine and surgery we could actually go to clinics and see the conditions.

A lot of the tutorials are unstructured and the tutors give a lot of their time.

Some are really good. The ones that got the whole class involved were good. The ones I disliked were the lectures. The demonstrations were good. The tutors give the tutorials after the lectures and it worked very well.

One of the students brought up a point about students practising on each other in College, the methods and

procedures of handling patients. The students considered this method inappropriate because the students are not doing it with patients and consequently students' attitudes towards this method are negative. According to her:

When it comes to handling "patients" at College, you are doing it with each other which is ok because it has got to be done like that. It is a very false situation because you don't take it seriously because it is your friend. Because you are not doing it with patients it is very easy to forget.

Evaluation

Evaluation in the case study focussed on student assessment, evaluation of the course, and staff assessment within the training programme.

Assessment of students on the course is influenced by the policies of the College of Occupational Therapists.

According to the head of department:

We have to assess students according to the regulations of the Examination Standing Group, Scotland, of the College of Occupational Therapists, so there is a very definite scheme of assessment which we must follow.

In the actual procedures, the College of Occupational Therapists' policy on assessment requires students to take professional examinations at the end of each year of training. The first professional examinations are in anatomy, physiology and psychology at the end of the first year of training. The second professional examinations

are in medicine, surgery and psychiatry at the end of the second year. The third professional examinations are on occupational therapy applied to physical disorder and psychiatric disorder and are common to all three Scottish schools. These examinations are internally set but approved by the Examination Standing Group and the external examiners moderate the marking in all three schools (each with their own examination paper). These professional examinations carry seventy percent of the total mark for each course. Some of the Occupational Therapy tutors in their comments feel the College of Occupational Therapists' policies on assessment in the present course create some problems and constraints. For example, one of the tutors said:

The policy on examinations at the end of the course tends to reflect the emphasis that was put on the course content. For instance, in our present course, we have a system where the first two years the students have professional level examinations in anatomy, physiology, psychology, medicine and surgery. The occupational therapy input is not examined on that basis until the third year, and I think that is a major problem in the present system because as far as the students are concerned the importance goes to the things they get examinations on. That happens whether one likes it or not. We have to conform to that regardless of what we examine on internally, other than that, the students tend to see the emphasis on the external examinations.

Another tutor, expressing dissatisfaction about the College of Occupational Therapists' policy on assessment, said:

We are not satisfied with the structure of the final examinations but that will be changing in the new course. The present situation is imposed on us because of the system in Scotland with all three schools sitting the same qualifying examination. We feel that it is unfair for them to be confronted with an end of course examination, if they haven't had experience in similar examination setting prior to that. We feel it doesn't necessarily give everyone the opportunity to show their best. So, that is good reason for having end of term tests.

The department has internal assessment which consists of continuous assessment carried out in the college by the staff of the department. These internal assessments carry thirty percent of the final one hundred percent of end of year assessment in each academic course.

In the internal assessments, students' course work is assessed by mid-term tests which are set and marked by the occupational therapy tutors on the courses, and class examinations at the end of the term which are set and marked by the lecturers. So that students do not get too much happening at the same time, a definite programme of assessment is drawn up in consultation with the lecturers and the tutors in that they must give the tests at certain times. The mid-term assessments are not always tests. Sometimes they can be assignments or projects.

The making up of the examinations is a joint responsibility and consultative process between the lecturers and the

tutors. For example, in anatomy, the anatomy lectures are given by an anatomist and two of the occupational therapy tutors do the tutoring. So, when it comes to assessments for this course, these three will liaise with each other and compile assessments which they will administer to all the students. There are full consultations between the occupational therapy course tutors, and the lecturers who give the lectures, about the content of the assignments and the examinations.

Each term, assessments in the academic subjects are in a similar form to the professional examinations and are usually of essays and short notes types. This is done with the concern in mind that students need practice in that type of examination format.

In the internal assessment for occupational therapy courses various methods are used, depending on the individual tutors and the subjects, as will be seen in the following comments when the occupational therapy tutor in psychology surgery and occupational therapy application said:

In the psychology course we use assignments and what we ask the students to do is to observe a patient and to write their observations on the patient. They are given a list of headings to observe about people. Typically, though, in psychology we also tend to follow the examination format just on the basis that they need to practise on examination techniques because they have to sit one eventually, obviously.

The examination format is one hour. They have to answer a short question component of the examination which consists of three out of five short notes plus the other half will be an essay.

In surgery, the assignment is usually based on the examination and is a short note format. The occupational therapy application ... we are much more flexible for instance, we require them to write-up information that is pertinent to what we feel that they are going to need when they are practising therapists.

Another tutor said:

I prefer the use of case histories, patient observations, but I have done the whole range, i.e. examinations, essays, case observation from clinical practice. I am very much more keen on the essay - the open book type questions where the students have to go away, research the materials and present it within say a framework of a thousand words or so. So, I favour these types of assessments but, in saying that, we are within a system that has examinations, so I still participate within that.

The occupational therapy tutors do not seem to be keen on the use of examination as an assessment method. Their feelings could be summed up in one of the tutor's comments when she said:

I don't like examinations because I think that memory and the ability to write fast are the two things they generally test.

The practical skills are assessed at the end of each course.

Assessment of students in clinical practice is done separately. The way this is done according to the head of the department, is that:

The students' performances of clinical practice are based on at least four separate clinical supervisors' assessments. They comment on the forms supplied by the college, they grade the students on the form and we arrive at an overall grade by an average of at least four and this is then presented to the external assessors who come for the third professional examination.

In grading the student for the internal assessment, the college uses a range of grades from A to E. It is the college's policy to give grades to their students and not marks.

In general, the students seem to be more in favour of the continuous assessments than the end of course examinations. Their comments suggest the continuous assessment is to the advantage of the students. For example, three of the students in their comments said:

Assignments were better because you could actually go away and do your own work whereas in examinations, people read the questions wrong and they panic and they get a straight fail.

I think it is good that the whole course didn't rely on final examinations. We have continuous assessment and it helps you to keep up with your learning.

Some students fail because they are afraid of examinations. They may do well in assignments they have to hand in.

The students were able to express different concerns about the assessment system. For example, one of the students, commenting on the open book assignment, said:

The main problem I found with the open book assignment is that there are not many copies of books put in reserve in the library for students to use and there are so many of us. If you are lucky enough to get a copy of the book from the library, because of the demand, you are rushed.

This seems not to be a criticism of the use of open book assignments as an assessment but rather that one of its weaknesses is that there are not enough facilities or materials to do the work.

The students do not seem to be in support of the grading system practised in the school whereby students are given grades ranging from A to E, not marks. This is not only in academic subjects, and occupational therapy courses but also in clinical practice. Three of the students, commenting on this issue, said:

I personally don't feel the grade system is good because it makes people compete. I prefer the pass or fail system whereby you are competent or not. I mean there is a lot of competition among us as to who gets what mark. People are just working to get good grades in examinations.

I think the grading system is bad. I prefer the pass or fail system.

The students' comments may reflect possible weaknesses in the grading system in assessment.

One of the students felt the use of a grade system in marking students in clinical practice is inappropriate because of the nature of the different placements. Her comment was:

I prefer pass or fail in clinical practice. There is discontinuity between different clinical placements because not everybody is going through the same clinical placement and there are variations between people's expectations. So, I prefer pass or fail.

Another problem identified by students on clinical practice is possible personality conflict between the supervisors and the students. One student said:

It is quite unfair. I found among the clinical supervisors big discrepancies from hospital to hospital. I think the college gave the clinical supervisors guidelines in assessing students but it becomes a personal thing between the student and the clinical supervisors. It is really unfair, a student has to be marked down because a supervisor doesn't like him/her. I really couldn't see a way round it and we can not really come up with a suggestion, unless they are forced to use the guidelines.

The opinions of the occupational therapy tutors differ as to the amount and frequencies of assessments in the course. Two of the tutors said:

The amount and frequency of assessments in the course I found to be too much basically. Students are over-assessed in general I would say. We have at the end of term, major examinations in academic subjects, mid-term assignments in some subjects and occupational therapy subjects are all examined at the end of every term.

I think the amount and frequency of assessment in the course is quite high. We have actually been told we possibly over-assess because in addition to that was all the continuous assessment and clinical practice as well. Students feel they have been looked at, got at, and generally observed most of the time. In total, I don't know what the assessment is, but every six weeks for my subject, and every other subject as well. Almost every week they are doing assessment. If we think about second year, this term they have been assessed twice on medicine, surgery and psychiatry - one at the end of term and one in the middle. They will have some occupational therapy assessments, sociology, work study, printing and woodwork. It is quite a lot, and quite stressful.

However, two other tutors do not share this view:

I don't think we over-assess them. In each academic subject they have one mid-term assessment and one end of term examination. So that in any academic subject they've got three examinations and three assignments. So that is not bad. They tend to have occupational therapy type examinations at the end of term as well in first and second years. In some occupational therapy subjects they also have to hand in folio diaries which may take the place of end of term examinations. It varies with individual subjects.

I don't think our students are over-assessed. I think it is just about right. Twice a term I think is reasonable.

But how about the students' views about the amount and frequency of assessment they have to do in the course? The students' comments suggest that they do not feel over-assessed in the course:

I would say for me the amount and frequency of assessment is just about right from the point of view that you are trying to learn work every four to five weeks and you are not waiting till the end of the year.

I think the assessments in college on the whole were quite appropriate. We had assessments once every three to four weeks.

The assessment of the whole training programme is done annually in a number of ways.

The students are asked to write an appraisal of their part of the course. The first year students write about their course, so do the second and third years. Sometimes some of the points the students want to write about in their appraisal have already been discussed at the Student-Staff Consultative Committee of the course. All the members of the Course Committee, that is to say, people who represent teachers on the course, are also invited to submit written reports on their areas of the course. The occupational therapy departmental staff review students' performances on the course and look at them

from the professional practice point of view. From all these pieces of information, the head of the occupational therapy department, as the course leader, will write an annual appraisal which is submitted to the Academic Scrutiny Committee and it may set up small working parties to examine and report on particular issues.

As to the assessment of staff, the head of the department has this to say:

I don't formally assess my staff and I am glad that I am not required to do that. I think any head of department who does not know how her staff are functioning is not doing her job properly. You know how your staff are functioning by the results they produce, by students' reactions to the staff, as well as the standard of work the students produce. From this you can tell fairly quickly if something is not right and discuss it with the individuals concerned. I try to provide opportunity each term for staff to discuss individual concerns with me but this is not formally structured.

In conclusion, this chapter has looked at the policies and practices of curriculum of two occupational therapy training programmes. The findings in this chapter as well as our discussions in chapters 2 and 3 and our findings in chapters 5 and 6 will now be looked at together, to enable us to design the Nigerian programme. This is presented in the next chapter.

CHAPTER NINE

A CURRICULUM MODEL FOR OCCUPATIONAL THERAPY
TRAINING IN NIGERIA

9.1 Introduction

This chapter will draw upon the theories and practices discussed in the previous chapters of this study. The purpose is to arrive at the general principles which will guide the construction of the Nigerian programme. In doing so, it must be mentioned that the previous chapters do not necessarily deal fully with all the issues. Likewise, not all issues they deal with are needed in this study.

Therefore, the discussion to follow will focus only on a number of major areas of issues that are of concern and relevant to this study, such as programme aims and objectives, content and structure, teaching and learning, and assessment and certification.

9.2 Aims and Objectives

Aims are broad statements of intentions which guide the programme. They do not specify the content or provide 'targets' for the teaching and learning. (These are called 'objectives'). They do, however, suggest principles which can be used to select appropriate content and objectives.

In deciding on the aims, I have found it necessary to look at two main influences: the influence of Nigerian

Government policy, and that of the occupational therapy profession itself.

The first, Government policy, must be taken as 'given', in the context of a study which aims to arrive at a plan for implementing the policy. However, Government policy itself is at a very general level, and much has to be done to interpret it in terms of occupational therapy practice and training. The main intentions of this policy were set out in Chapter 1 and are:

- (a) to increase the number of occupational therapists, thereby their availability throughout the country
- (b) to create a Nigerian profession, and hence a contribution to national self-sufficiency.

The conditions within which these would be realized, a three year full-time, degree course located in the same institution with a physiotherapy programme, are also laid out by the Government and will influence the practical decisions to be made about how to achieve the aims.

While the Government may decide to provide occupational therapy as a service, it is to the profession we must turn to have some idea of what occupational therapy consists of, and how a pre-service training programme would assist in providing the service. This was discussed in Chapter 2.

Other influences have been found less important in determining aims. For example, the survey of current practice in Nigeria may help us to plan realistically, but does not suggest what the new programme should aim at; the U.K. case studies show that aims must be related to the context, but again do not define the aims. In these cases and in the World Federation literature, the discussion of aims is not obvious, and we can not derive our aims by inferring other people's aims from such sources.

It is necessary to distinguish between the aims relevant to occupational therapy provision in the country and the more limited goals of the training programme. The programme can not produce a fully fledged professional force able to meet all the country's needs. It must develop priorities, equipping students with the most important knowledge and skills so that appropriate initial competence is assured, and lay foundations for further development during professional experience and further in-service training; and it must select as priorities those kinds of knowledge and skills which pre-service training can most effectively provide.

These considerations will lead us to a statement about the pre-service programme aims: its priorities in teaching students the abilities and attitudes they will need as practising professionals - knowing that

not all of them can be covered effectively before practical experience and in the course of a three year institution-based programme.

Thus, goals are connected with knowledge and skills needed for doing the job. Everyone, for example, the WFOT and the U.K. literature, promises to guarantee knowledge and skills in their graduates. A Nigerian programme must also guarantee knowledge and skills in their students so that the students will be fully competent to carry out all the functions of occupational therapists:

1. evaluating patients' problems
2. developing appropriate treatment plans
3. implementing such plans by selecting the most appropriate procedures
4. reviewing patients' conditions and taking appropriate decisions
5. reporting and documenting findings about the patient
6. managing the programme of therapy.

These have been discussed fully in Chapter 2. There is no mention in any of the literature of relating goals to professional attitudes but I believe this to be important. This covers attitudes to patients, attitudes to one's colleagues and other professional staff and attitudes to the public such as patients' employers and relatives. Students have to be informed what professional attitudes should be

and how this is dealt with in other professions.

During the course we can hope to foster professional attitudes by giving students knowledge about professional behaviour and providing them with positive models (especially during clinical practice). We can not 'guarantee' continued professional behaviour. This will need to be developed and monitored after graduation when they mix with colleagues other staff, patients and the public. We should be under no illusion that the course can teach everything about occupational therapy in three years. The course can only lay foundations of knowledge and skills in the students before they enter professional practice. My thinking is that while in the course, further personal and professional development in the students can come about through independent study towards the end of the course. The same can be achieved in different ways after they graduate from the programme, for example, through experience on the job, exercises involving research, in-service training of a general of specific nature and study for higher degrees or other qualifications.

In summary, the aims of the pre-service programme are designed to meet the particular demands of occupational therapy circumstances in Nigeria. In meeting the aims of the programme, the goal of the pre-service programme is to lay in the learners the foundation characteristics of knowledge, skills and attitudes required for entry-level performance into the profession.

9.3 Programme Contents and Structure

In order to realize the goals of the pre-service programmes, we need to pay attention to what to teach, how we select this and how we organize it.

Contents

The issues here, therefore, are what content should be included and what priority should be given to various kinds of content.

To resolve these issues, it is useful to draw mainly from international and U.K. literature, taking into account Nigerian information and the case studies. Some issues relating to selection of content can be set against the curriculum models described in Chapter 3.

The international and U.K. literature describes the traditional content of occupational therapy courses across the world. Firstly, there are traditional medical subjects: anatomy, physiology, kinesiology, psychology, sociology, medicine, surgery and psychiatry. These teach students about the normal and abnormal functioning of the body and mind. Secondly, there are occupational therapy subjects such as Principles and Theory of Occupational Therapy, Practical Skills of Occupational Therapy, Management and Administrative Procedures. These aim to teach students about the ways in which therapies

can affect body and mind, how the therapies are carried out and the general workings of the occupational therapy profession. There is also the learning of occupational therapy skills: of diagnosis, planning, treatment, re-evaluating, communicating findings; and the practising of these skills in realistic situations through clinical practice.

The author's experience and knowledge of the Nigerian context suggest that while these components should be usefully retained, one should look carefully at what is included in each. For example, maintaining medical subjects as separate components is valuable in ensuring that students have a broad general understanding of the working of mind and body which will allow them to put their specialised occupational therapy knowledge in perspective and allow them to maintain dialogue with other professions. However, there is a tendency for these 'pure' subjects to be taught with little relevance to occupational therapy and for reasons of 'academic status' rather than usefulness. These issues have been discussed extensively in the U.K. case studies in Chapter 8. The argument here is not that these subjects are unimportant but that they should have less emphasis, and certainly what is taught should be more directed towards occupational therapy.

The description and definition of occupational therapy in Chapter 2 is therefore a valuable device for 'screening' possible content before deciding what to select. This is

a very general consideration. However, in the previous section we defined some aims and objectives which the programme should have and these also can be used to consider content for inclusion. (In turn these relate to the discussion of curriculum models in Chapter 3).

Thus, when we have stated objectives, the contents selected must be such as to allow these learning objectives to be attained (Tyler). This principle will be valuable in areas such as the training in occupational therapy skills where the content of clinical practice will be determined by the skills that students are to attain. Where specific objectives cannot be stated, they cannot prescribe the content; nevertheless, the principle can be applied, of selecting content that is consistent with the aims. Aims are not stated as something students will attain (by definition, an objective) but they suggest the kind of experiences they should have. So: in areas of knowledge and understanding, we might in principle be able to define specific objectives, but it might be impractical to do this in detail; nevertheless, we could select content in relation to the aim, say, of 'providing students with an understanding of the procedures, attitudes and characteristics of being a member of the profession':

Thus, our consideration of course content suggests in principle that:

1. The programme should be multi-disciplinary
2. General aims should be stated

3. Objectives should be specified for individual courses, where this is appropriate
4. The principal areas of knowledge to be acquired are: biomedical sciences, behavioural sciences and occupational therapy clinical/practical knowledge
5. Bio-medical and behavioural sciences knowledge should be selected for inclusion because of its relevance to occupational therapy
6. Priority should be given to theoretical and practical courses on occupational therapy
7. The programme should include theoretical and practical studies
8. The programme should reflect the special needs and characteristics of the Nigerian situation.

Structure

Here we are concerned with establishing clearly the principles on which we will be dividing up the subject matter into units or strands and how the teaching of them will be organized so as to provide the best sequence and integration of the components. Such structuring might be derived from traditional subject divisions, or kinds of teacher expertise, or kinds of facilities and accommodation needed, and would certainly be influenced by them.

There is a traditional sequence in programme structure (discussed in chapters 5, 6 and 8). This seems consistent with both Tyler and Stenhouse, though by no means necessarily derived from either. Tyler's sequencing principle (students must master X before they can understand Y), suggests for instance that students should learn anatomy before learning medicine; Stenhouse's principle of gradual induction of the student (in this case into the profession) suggests a carefully designed series of clinical practice experiences.

This general ordering of content and experiences is an important issue.

I think it is done in the right order.
I think psychology is good to lead on
to psychiatry because you have got
some understanding of the way the
mind works before you go into
psychiatry.

(Student, Case Study No. 1, Chapter 8)

My second placement was in neurology
and we have not done neurology -
we have done the basic neuro-anatomy
but we haven't done any conditions.
It was just worthless. It didn't
really prepare me for the placement.
You could teach practical skills to
patients and you don't really know
why you are doing it.

(Student, Case Study No. 1, Chapter 8)

One of the weaknesses in the course, I think sometimes is because of the nature of learning. We put things together into compartments. Sometimes we forget things have to be intermingled. As an occupational therapist, you can not have things in compartments, everything has got to be intermingled because people are not in compartments.

(Occupational Therapy Tutor, Case Study No. 1, Chapter 8)

Personally, I quite like the idea of first year being a grounding in psychological and anatomical sciences and the medical sciences applied on top of that in succession.

(Occupational Therapy tutor, Case Study No. 2, Chapter 8)

I would say it is quite a good idea, the way our course is organised. You are doing all your main block practice once you have done all your theory. Then you can put theory into practice.

(Student, Case Study No. 2, Chapter 8)

We get absolutely no psychiatry before the end of first year. We did psychology but anything like basic patient handling was related to physical, and then, when we went out on placement at the end of first year, not all the students could go to physical placement. Some had to go to psychiatry without any course in psychiatry at all. Even those of us who went on physical placement then, didn't have enough knowledge of medicine and surgery. It was all very vague to us when we went on placement.

(Student Case Study No. 2, Chapter 8)

To be an effective occupational therapist, a student must have a variety of knowledge and skills, and must put these together: it is not enough to have 'covered' courses and then perhaps forgotten what has been learned. Thus, it is important that the early learning should enable the later learning to occur, and that the later learning should assist some retention of the earlier learning by exemplifying it in use. The traditional order also helps maintain responsibility towards the public and patients. We cannot let beginners into the wards, but we cannot delay direct experience too long without hindering student commitment and discouraging relevance.

We should note that while often we decide the sequence on the argument that A must precede B, nevertheless in the case of professional development, we may also argue that a main issue is to expose students as early as possible to the practise of the profession, as well as allowing the students sufficient time for contact with patients in the programme. Since our concern is with occupational therapy, we must allow plenty of time for occupational therapy subjects to be studied in detail. To allow this, we may have to be selective and choose from biomedical and behavioural subjects those topics which are relevant to the practise of occupational therapy. This may lead to less time being spent on the medical subjects. However, if the teaching of occupational therapy subjects can be explicitly related to the medical content, that will help students retain and develop their medical knowledge

better, perhaps, than in the past.

Thus, the principles for programme organization suggest:

1. Students should work from prior to new knowledge.
2. Students should be introduced to the practice of occupational therapy from early in the programme.
3. The strands of bio-medical, behavioural sciences, and occupational therapy theory and practice, will be studied concurrently.
4. More time should be given to the study of occupational therapy theory and practice than the study of bio-medical and behavioural sciences.
5. The actual structuring of the programme will have to take into account the circumstances of Nigeria, for example:
 - a) The mandatory conditions within which the programme must operate e.g. length of programme, units of learning.
 - b) Occupational therapy circumstances, local needs, provisions which exist for clinical practice, and location of the school in relation to distances from clinical placements.

9.4 Teaching and Learning

Teaching and learning are fundamental aspects of implementing the programme, the general principles for pre-service programme objectives, contents and structure having been

identified in the earlier discussion.

Teaching methods

In discussing teaching and learning, we are concerned with the selection of appropriate teaching methods for our course, who should be responsible for teaching what, to what extent would the views about ideal ways of teaching and learning be affected and modified by characteristics of the Nigerian situation, and what relationship, if any, there should be between teaching and learning methods and different parts of the curriculum.

Our discussion of content and organization suggested that students will be learning different things, for example, knowledge, skills and attitudes; and that the learning will take place both in the school and in the clinical centres. The literature from the World Federation and Professional Associations is uninformative on how the teaching and learning at the school or elsewhere should occur. The study of British institutions, including the case studies, showed teaching and learning to be conducted in a variety of ways: lectures, tutorials, and practicals. The use of specific method will invariably be the judgement of individual teachers - the issue discussed extensively by occupational therapy tutors in the case studies (Chapter 8). In choosing teaching methods, we have to consider the benefits and the reasons.

The lecture method, though widely used, is generally not considered one of the best methods of teaching. The method, some will claim, does not often provide for interaction between the lecturer and the students. This we have identified in the case study - Chapter 8. In relation to the lecture as a teaching method, Bligh (1971) argued that:

1. With the possible exception of programmed learning, the lecture is as effective as any other for transmitting information, but not more effective.
2. Most lectures are not as effective as more active methods for the promotion of thought.
3. Changing students' attitudes should not normally be the major objective of a lecture.
4. Depends on the effectiveness of the lecturer and that in turn depends on his technique.
5. Organization of subject matter is also crucial.
6. Lectures are usually regarded as instructor-centred and as providing an authoritarian social situation compared with student-centred discussion methods which are described as "democratic".

He suggested that to achieve objectives different from (1) above, other teaching methods should be used wherever possible. Giving these types of criticisms it may seem unreasonable to rely on lecture methods. But, the method does have certain merits, for example in presenting information to large groups of students and information not available to students elsewhere. The method is cheap, convenient, economical in time and in its use.

Nigerian students are used to a style of education which involves passive reception learning: lectures, swatting from textbooks, 'recall' testing in large essay-style examinations. This is what they are used to, so this is what they will expect and welcome. To offer them anything else will be something of an uphill struggle. (This is in striking contrast with the U.K. case study evidence). Therefore, we must be gradual in introducing them to different ways of learning. Similarly, those who teach in Nigeria are familiar with this tradition, and will see lecturing as generally an appropriate method to use. They will expect students to listen attentively to the views of someone who is recognised as an authority, and may find the idea of more interactive approaches disconcerting: they are unlikely to have practised these methods and may be aware of lacking the skills required.

If we accept that lecture methods have undoubted limitations, it is also reasonable to expect the limitations can be mitigated by supplementing lectures with other methods such as tutorials, practicals, case studies, discussion, seminars, and simulations. More active learning probably occurs through these methods. They are appropriate where students must learn to use their knowledge and understanding or develop skills, for example, learning the skills of professional technique and attitudes, as when students learn from instructors acting as models. Hence, the combination of different methods will be good in Nigeria, as well as for

occupational therapy. For example, the kinds of learning in the Nigerian programme for which lectures will be most suitable will be knowledge and understanding of content which is well established and which the students need not develop in any personal way but merely accept, for example, the basics of medical subjects and information about occupational therapy. Nevertheless, to ensure that students do not simply learn those things for the examination and then forget them, they need opportunities to use and relate them to occupational therapy. Therefore, we can use other methods (tutorials, discussions, seminars, case studies) to lend support to lectures, give students more individual guidance concerning specific learning difficulties, provide relevance and relationships, develop thinking, clarification of points and encourage students to actively participate in the exchange of ideas. Adopting this approach can help to make what is learned more permanent and meaningful. Equally important is that we know what students are familiar with on entry to the programme, namely school leavers used to lectures, the chalk and board method of teaching and learning. We know that we must gradually introduce them to different methods of teaching and learning. Since we are simply providing them with basic knowledge in the first year, it may be appropriate to use lectures. In the second and third years we will be teaching towards the application of knowledge and we may then introduce more and more methods that will take students away from the lecture type of teaching:

methods such as practicals, group discussion and seminars. Hence, we can use any or a combination of these methods depending on what we are teaching and what kind of ability we want our students to learn.

At the same time, we have to consider certain things about the teaching staff in the programme, for example, likely preference for certain teaching methods, initial competence to employ various methods suggested, possession of different kinds of expertise for teaching different kinds of knowledge. We will have to use the individual staff expertise as well as consider staff training and deployment of individual staff.

Although the use of computers and audio-visual aids are the practice in some British institutions and have their particular merits, we have to consider the circumstances in Nigeria where these technologies are not generally available, few people are knowledgeable in their use and students are not familiar with them as means of teaching and learning.

Another aspect of teaching and learning is that of private study. We should not expect students to be kept busy in the classroom all the time. Students need time to do assignments, read up information, spend time in the library and develop their knowledge and thinking. Allowing time for private studies can affect important

decisions we have to take, such as the amount of contact time between students and staff, how we structure the teaching time-table, what we can cover in the classroom and what we must expect students to learn outside the classroom. In general, these matters are not adequately considered in most programmes.

Who should teach?

a/h
The tradition in occupational therapy training is for specialists to teach the subjects of bio-medical and behavioural sciences and for occupational therapists to teach the occupational therapy courses. In some cases, activity instructors are employed to teach practical skills. These matters are discussed in Chapters 6 and 8. It would be preferable for occupational therapists to do all the teaching in the course. They can draw all the knowledge together more effectively, so that students can see relationships between various areas of learning and why they have to learn certain things. They can relate teaching to practice. They know the knowledge requirements for the practice of the profession and the specific needs of the students, thus making learning more meaningful to the student. One could also expect occupational therapists to teach practical skills. They are trained and experienced in the use of these activities in clinical situations.

Specialists are traditionally used, one might argue, for the reason that they have authority within their subject, and so other professions will give recognition to the course more easily. Often such specialists deliver one course for several professional groups - hence there is economy of effort. However, the course may not be quite right for any one group and the specialist may have little authority over the actual practice of a particular group, such as occupational therapists. This will produce a tendency towards dry lecturing with students and staff complaining.

We had outside lecturers for most of our subjects. They just lecture. Some of them are better than others. Some simply read the lecture notes and walk out and that is their job done. Some of them didn't even give us the chance to ask questions.

(Student, Case Study No.1, Chapter 8)

The lecturers maybe (are like this) because they are specialists in those areas. Sometimes you find it difficult to understand exactly what they are trying to get over. Whereas the tutors explain it in much more simple language. I really think if the tutors hadn't been doing that, the students will be in trouble.

(Student, Case Study No.2, Chapter 8)

Some of the courses are not taught by occupational therapists. The problem sometimes is in the perception of the person teaching it. The anatomy and physiology is a classic one I suppose. That is the one I know where there are quite a lot of problems because the person teaching it tends to put too much emphasis on the subject, compared to maybe what the students actually need to know to be a professional occupational therapist. That type of thing can become a problem and it can happen in any subject. People tend to do their own specialty without really looking at the needs of the people they are teaching.

(Occupational Therapy Tutor,
Case Study No.2, Chapter 8)

The question, then, is: why cannot we use occupational therapists? Is it because they are unacceptable to other professionals or because they are not available, interested or competent? If we can use occupational therapists in this fashion, it would be an important move in developing the profession. Ultimately in the Nigerian programme we might require all teachers to be qualified occupational therapists. Initially in the Nigerian programme, it may prove difficult to recruit Nigerian occupational therapists to teach the bio-medical and behavioural sciences for reasons of lack of expertise which may exist in these subjects. Hence, we may consider using specialists. However, one might aim to exercise some influence on the teaching to ensure its validity and relevance for the occupational therapy students. Thus, occupational therapy tutors might sit in on these classes to monitor

teaching styles and contents; specialist lecturers might be asked to teach in certain ways and be given specific instructions as to what to teach and how much time they have to teach them. Also the occupational therapy tutors could be asked to give follow-up tutorials to students on these subjects.

Thus, in summary, our principles for teaching in the Nigerian programme suggest that:

1. A variety of teaching methods should be used.
2. The teaching methods used should, as far as possible, be those that will encourage students' involvement and participation in the courses.
3. The methods of learning should be appropriate to the kinds of studies taking place at each stage in the course (first, learning basic knowledge by lectures, moving on to practising skills and eventually to carrying out one's own investigation).
4. The methods of teaching should be appropriate to the maturity and previous experience of students, who are for example, starting as school leavers and finishing as fully independent professions.
5. The methods of teaching should take into account the circumstances of Nigeria, for example, the skills of teachers available, and the resources we have available.

9.5 Assessment

In this theme, three stages at which assessment occurs are considered: at entry, during the course and at the end of the course. Each stage has a different purpose.

Assessment at entry into the course

Here, we are concerned with assessing entrants into the programme: who we should allow into the programme and on what basis we should make this decision.

If more people apply than there are places in training, assessment will allow us to select the right number. Based on knowledge of occupational therapy worldwide and in Nigeria, we can predict that there will be more applicants than places. The 'cutting down' requires to be acceptable to the public. It also requires us to 'spread out' the applicants in an order of merit so that we can select whatever proportion we need by adjusting the entry standard from year to year. Usually, both of these requirements are met by using school certificate results which provide grades for different levels of performance, and the grades required for entry can be varied according to supply and demand. People generally accept such certificates as a way of selecting for many different occupations and kinds of training.

However, there are more jobs in occupational therapy than we can train occupational therapists for at present, while, at the same time, we have to accept that not everybody who applies can be given admission. So, the selection needs to be precise, because we don't want to waste precious places by having to fail students later on. This means two things:

- (a) Making sure that entrants have all the knowledge and skills to cope with the course itself.
- (b) Trying to predict those who will be good occupational therapists.

The first (a) is a matter of matching the course demands against what they have already learned. Since generally (WFOT literature, U.K. schools and in Nigeria) we base entry on secondary school education, we need to know what we can assume they have learned there. If there are particular things we need (e.g. English, Science subjects), we can require them at entry OR we can provide some of them during the course itself if otherwise we would be rejecting seemingly good candidates. Or we might give them a specially designed test at entry to supplement the general information provided by school examinations.

We should note here that this is a specific matching of particular abilities needed in the course and not an attempt to use grades as a broad measure of talent, intelligence or general academic ability.

The second (b) is a matter of making a prediction, three years ahead, about young people who may change, and will certainly learn a lot, during our course, so that any prediction is likely to be shaky. If we select wrongly, we can make two kinds of errors:

1. Exclude 'good' occupational therapists.
2. Accept 'bad' occupational therapists.

We will never know about (1). We can try to minimize (2). Preferences and interviews are recommended in WFOT literature and used in the United Kingdom (see Discussion in Chapter 6), as a way of screening applicants to reduce both kinds of error.

Interviews can be criticised, for example on the grounds that interviewees can sometimes over- or under-react to an interview situation and also that interview periods are often too short to know everything one needs to know about an interviewee. We may nevertheless have to use them for lack of any better means, though we should be prepared to review their effectiveness in the light of evidence about errors in selection detected later.

Assessment at the end of the course

This concerns the assessment of all the learning that has taken place in the course, leading to certification. Graduates will go out to practise on their own, and so

the qualification must guarantee that they are fully competent in all the necessary skills and have the knowledge needed to practise and to develop their abilities further. The qualification itself will not be graded or awarded at different levels: this is normal world-wide.

The purpose of the assessment is to be sure that only those who are capable of doing so properly may practise the profession. We want to assure the public of their competence. The assessment would therefore cover the range of relevant skills in some detail and test the students in ways that closely simulate the conditions in which their abilities will be used in subsequent practice.

There are however strong pressures to retain a substantial terminal examination. If it is standard practice in occupational therapy worldwide, and if other professions do it, it may be necessary to the credibility of our programme. It is also a very convenient and generally accepted basis for degree awards. On balance, it appears necessary to have a final examination, but it will be important to consider a style of examination that will reduce the most negative aspects of the traditional sort.

Traditionally, professional qualifications are usually awarded on the basis of performance in a diet of final examinations. The argument in favour of this is that

it ensures that at least at one point in their career, the students are required to bring together all that they have learned and demonstrate a wide range of competence. Against it, we can argue that the ordeal of these examinations is an artificial one, that it gives little guarantee that what is tested will be retained, and that as a rule, students are not required to demonstrate mastery across the board, but often pass on the strength of blind recall unevenly distributed across their courses.

Therefore, the argument for terminal assessment is for a situation whereby professional examinations can be conducted in both written and oral/practical form. Both examinations will concentrate not on individual courses (as is the case during the course) but on the synthesis and application of all the learning that has taken place in the programme. Both examinations will take place at the school. The written examination will take the form of essay questions. The procedure will be such that there will be two papers, one for occupational therapy application to physical and surgical conditions and the other for psychosocial conditions. Each paper will last for two hours. The oral/practical examination will be conducted with experienced occupational therapists as external examiners. There will be two examinations, one on physical/surgical conditions and the other on psychosocial conditions. Each examination will last thirty minutes. For each examination, and in the presence of the external examiner and the occupational therapy tutor, each student will be given a question. The student will have

Si / ten minutes to plan a treatment programme, ten minutes to demonstrate treatment procedures and ten minutes to discuss the treatment programme. A patient may be provided for this purpose, or someone who is able to emulate a patient. The two examinations (written and oral) will allow the school to have control of the assessment, avoid examination malpractices such as corruption and leakage.

The questions in both examinations will represent typical cases and students will have to pass each paper. The marking system will be the same. Our purpose in these examinations is to ensure that students are competent in all the required skills and areas of knowledge. Therefore the examination must cover both of these. Students must also be able to show the skills in relation to each area, and to show them reliably, every time they are asked. There is, therefore, in principle, little justification for offering a choice of questions, or for allowing students to avoid having to answer a full range of test items successfully. We need, therefore, to create an examination system in which students have to show satisfactory performance against a 'grid' covering both dimensions of skills and different disabilities, which may be tested in a variety of ways. (Table 9.1).

TABLE 9.1

Specification Grid for the Examinations in the Nigerian Programme

CONDITIONS		Skills	Diagnosis	Planning Treatment	Applying Treatment	Evaluating Treatment	Communicating Treatment Results
PSYCHIATRIC CONDITIONS	Psychoneurosis						
	Affective disorder						
	Organic disorder						
	Personality disorder						
	Mental handicap						
PHYSICAL/SURGICAL CONDITIONS	Respiratory system						
	Endocrine system						
	Locomotor system						
	Nervous system						
	Cardio-vascular system						
	Rheumatoid disease						
	Congenital disorder						
	Traumatic condition						

By not having a choice we avoid a number of difficulties for the examiner: for example, having to make all questions of equal scope, equal difficulty, similar structure and style, so that students cannot simply pick the easy options. In traditional examinations, students are required only to achieve a score of 50% which they may achieve in all sorts of different ways (full marks on half the questions, or half marks on all). This is not guaranteeing anything about the specific competencies they should have. We would want to create an examination covering both dimensions of skills and disability types (Table 9.1) and in principle should test each of these 'boxes' in the same way. In practice, this might be too extensive an exercise and so we would probably settle for a sampling of each of the rows and columns in the table. In principle, we would require students to 'pass' each item, to demonstrate all the competencies tested. Again, however, we might accept a proportion of 'errors' if they were purely random and did not cluster on any row for example 'psychoneurosis' or any column such as 'evaluating treatment'.

Thus the examination would consist of several compulsory tasks, which amongst them would require students to demonstrate all the skills of occupational therapy across all the common kinds of disability. This would be planned against a two dimensional 'grid of competencies'. Students would be marked as 'competent' or 'not competent' on each box in the grid; they would have to score almost

total success on each column and each row.

Assessment during the course

This comes between entry and qualification. Assessment will therefore mainly be concerned with checking that students are learning successfully what they should be learning from each part of the course. There is no need to reduce numbers, and ideally all students could be successful. If any are not, that is 'wastage' and attempts would be made to use assessment information to minimise wastage. For those who are deficient in certain aspects of the course, we can make provision for their strengths and weaknesses, for example, by allowing them extra tuition and allowing for one examination re-sit.

It is difficult to see a series of written papers as the most appropriate way of testing the different kinds of learning that are part of the training programme. Also, the circumstances of the written examination are very different from the circumstances of working as an occupational therapist. Again, the concentration of assessment in one pressurized period may be a poor guide to students' likely ability to use their knowledge and skills day-by-day in occupational therapy.

The methods used for assessment should match the kinds of ability being assessed. For example, if we wish to test knowledge of anatomy, we could, in principle, use many methods such as essay questions, short answer questions,

or multiple choice. But in the case of practical skills, not only do they have to have the knowledge but also the practical skills and techniques. So, we might decide that job simulation and oral presentations are more valid. Again, if we want to assess, say, attitudes to patients, and work, we would not use essays, assignments, multiple-choice, or short notes, because these methods do not provide for interaction with other people. Rather, we might use job simulation or oral examinations because they present opportunities for students to be observed and so for attitudes to be assessed correctly. So the methods would be different in the different parts of the programme. Generally, the assessment would be criterion-referenced: students would pass or not, rather than being graded. The assessment would not aim at awarding an overall mark, rather it would aim to record the various items of learning successfully achieved. Students could not compensate for failure in one area by being good at something else. But they could be allowed to repeat work and pass the second time.

Just as with the end of programme assessment, so, for each course, we would set out clearly all the abilities or areas of knowledge to be learned, whether as a list, or a two-way grid, or any other form that would match the structure of the course itself. Students would be expected to demonstrate a satisfactory level of attainment in each aspect of each unit. Just how a satisfactory

standard would be defined is difficult to state, and it will be largely a matter of 'expert judgement' in the first instance; thereafter, the monitoring of the students' progress should help us to revise standards in the light of experience. One principle, however, would be essential: the 'standard' would not depend on how many students achieved particular levels of performance. Thus, it might be the case that all students could easily achieve the required standard in some areas, and in other areas there might be a proportion of failures and students finding great difficulty. This would be perfectly in order, since some aspects of occupational therapy are bound to prove more difficult to learn than others. We should not set our standards by what students find easy or difficult to learn, but by the demands of the work of occupational therapy itself.

Two key issues in relation to assessment are those of validity and reliability. Both can be enhanced by using continuous assessment. In the case of validity, we are concerned with whether assessment is testing what it is supposed to be testing and not something else. In-course assessment would allow us to assess students in a way most closely integrated with the learning process and hence, most likely to be valid. (By contrast, examinations may often be less valid because they test in a more artificial way and depend on exam technique as well as students' abilities). In the case of reliability,

we are dealing with whether we have enough evidence to be sure that a student has learned something. Again, continuous assessment allows us to gather more evidence than a single examination. There is therefore every reason to take the in-course assessment very seriously as providing us with valid and reliable evidence about students at the time they are tested. The final assessment will then be directed mainly towards testing their retention and synthesis of the abilities learned during the course. This principle will apply to each unit, and to the degree programme as a whole.

Throughout, we are aiming to adopt the principle of identifying various essential items to be learned and checking that they have been. It would therefore be meaningless to adopt a system of weightings, so that different skills are more or less significant in deciding whether a student will pass the course. All must be satisfactorily achieved. While in practice we would probably have to retreat a little from this principle, we would, however, retain it in relation to relative importance of assessment at various stages. Thus, a student would need to pass on course work before sitting an end of course or end of programme examination; then he or she would need to pass that examination.

We have to accept that certain kinds of assessment may not be possible in the programme. For example, how the occupational therapists are doing on the job after

completion of training. Here, feedback from our professional colleagues would be helpful in the longer term.

Therefore our general principles in assessment are that:

1. At each stage - entry, in-course and at the end, assessment should be criterion-referenced, aiming to check whether students have or have not got the abilities which they require for their work.
2. The assessment methods chosen should match the kinds of learning that we want the students to achieve and so a variety of methods might be used.
3. Assessment during the course should assist students to learn, as well as checking that they have learned what was intended.
4. Assessment at the end must provide the public with a guarantee of competence and should justify the award of a para-medical degree-level qualification.
5. Assessment should allow the success of the course to be monitored.

In conclusion, the main aim of this chapter has been to demonstrate basic principles upon which we will design the Nigerian programme. This leads us to the next chapter, where the proposed curriculum will be presented.

CHAPTER TEN

THE PROJECTED CURRICULUM FOR
OCCUPATIONAL THERAPY TRAINING IN NIGERIA

10.1 Introduction

In Chapter 9, we looked at the general framework within which we would plan the Nigerian programme. The present chapter (Chapter 10) will now show what the principles identified in Chapter 9 will look like in practice. In doing so, a programme time-table (Table 10.1) and a course syllabus (Appendix 10) for the Nigerian programme, have been constructed. Some of the principles, such as those of teaching methods and assessment, can not be manifested in the time-table but the contents and structural principles can. For these reasons, the chapter has been divided into two parts:

1. Developing the course programme.
2. Putting the programme into operation.

10.2 Developing the Course Programme

This is concerned with the appropriate contents and the structure of the programme.

Programme content

The principles stated in Chapter 9 are reflected in the programme time-table (Table 10.1) and spelt out in statements in the course syllabus (Appendix 10). The contents incorporate several disciplines, reflecting the

multi-disciplinary nature of the profession.

The biological sciences (anatomy, physiology, kinesiology) introduce students to the normal structure and function of the human body and its system, and their relationships to body movement.

The study of behavioural sciences (psychology, medical sociology) will enable students to understand human behaviour and problems. The medical sociology course will examine Nigerian society in relation to social behaviour on the health-illness continuum.

The study of medical sciences (medicine, surgery and psychiatry) introduces students to diseases and illness which can affect the human body, its systems and the mind.

In the practical skills, students study a range of therapeutic skills and activities which occupational therapists use in the course of their profession, i.e. work, recreation and leisure activities, social and personal skills and equipment.

The study of the theory, principles and practice of occupational therapy introduces students to the profession's philosophy, models of practice and the occupational therapist's function in relation to a variety of health problems.

The clinical practice is a period of apprenticeship for the students, during which time they spend a proportion of their training in hospitals with occupational therapy facilities, gaining experience in dealing with a variety of patients under the direct supervision of qualified and experienced occupational therapists.

Programme structure

The structure of the programme contents is in accord with the principles identified in Chapter 9. These are reflected in Table 10.1 in terms of sequence, integration and time allocation (principles 1-4). In the first year, students will need biological and behavioural sciences, practical skills, theory and principles of occupational therapy and a short clinical practice in the capacity of observation. In the second year, students need medical sciences, continue with the study of practical skills, theory and principles of occupational therapy, including the practice of the profession. Students go on their first major clinical practice at the end of second year. The third year starts with students still in their first major clinical practice. This is then followed by the second major clinical practice. The third term is spent in school, reviewing all the clinical experience, completing a project in an area relevant to occupational therapy and preparing for the final examinations.

Integration in the course is enhanced in a variety of ways. For example, by the arrangement of the subjects. The arrangement of clinical practice allows students to complete necessary learning in school before proceeding on clinical practice. The students will spend brief periods in school after the first major clinical practice. They will also do individual projects in areas relevant to the profession. These are reflected in Table 10.1.

Our teaching methods will further enhance integration. The time allocated to various courses reflects individual course priorities in the programme. Students need more time to learn more about occupational therapy than about the other courses. They also need substantial time in a variety of clinical situations, to put into practice the various theoretical knowledge and skills they learned in school. Also, we are selective in what we teach in biomedical and behavioural sciences, omitting that which is not required to be studied in detail. Hence, programme content principles 7 and 8 and structure principle 4 are enforced by giving a combined time allocation of 80 per cent to the study of occupational therapy courses (25%) and professional practice (55%). Biomedical and behavioural sciences are given about 20 per cent. Also, the programme structure (principle 5) has been considered against Nigerian circumstances. Hence it is planned on a 3-year duration, 3 terms a year, 14 weeks per term. Clinical

practice is planned around two main health areas and is reflected in types of clinical experience (physical and psychiatric) frequencies and numbers of such experiences in the programme structure (Table 10.1).

The class contact time in the first year is 20 hours per week while in the second year it is 22 hours. This is designed to give students time for individual private studies and assignments. It also reflects the demand of the course in the second year. The students will spend about two-thirds of the third year in clinical practice. This leaves 18 weeks spread over the year for class contact time to be used for review of clinical practice, special study and preparation for the final examination. These are reflected in Table 10.1.

10.3 Putting the Programme Into Operation

This aspect of the course focusses on its organization and administration. We can also use the information here as part of our policy and guidelines for students and staff.

10.3.1 Admission Procedure Into the Programme

Here, we are following our principles for entry into the programme.

TABLE 10.1

Time-table Outline of Contents and Structure in the Nigerian Programme

	YEAR	TERM 1 (14 WEEKS)	TERM 2 (14 WEEKS)	TERM 3 (14 WEEKS)	TIME ALLOCATION (WEEKS x HOURS)	
SCHOOL - BASED PROGRAMME	1	Anatomy, Physiology, Kinesiology	Anatomy, Physiology, Kinesiology	Anatomy, Physiology, Kinesiology	38 x 4 (152 hours)	
		Psychology, Medical Sociology	Psychology, Medical Sociology	Psychology, Medical Sociology	38 x 4 (152 hours)	
		Practical skills in Occupational Therapy	Practical skills in Occupational Therapy	Practical skills in Occupational Therapy	38 x 6 (228 hours)	
		Theory, Principles and Practice of Occupational Therapy	Theory, Principles and Practice of Occupational Therapy	Theory, Principles and Practice of Occupational Therapy	38 x 6 (228 hours)	
	2	Medicine, Surgery	Medicine, Surgery		28 x 5 (140 hours)	
		Psychiatry	Psychiatry		28 x 5 (140 hours)	
		Practical skills in Occupational Therapy	Practical skills in Occupational Therapy		28 x 6 (168 hours)	
		Theory, Principles and Practice of Occupational Therapy	Theory, Principles and Practice of Occupational Therapy		28 x 6 (168 hours)	
	3		4 weeks in school		Review of Clinical Practice Special Study Preparation for Final Exams	18 weeks

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cont'd.

TABLE 10.1 cont'd.

Time-table Outline of Contents and Structure in the Nigerian Programme

CLINICAL PRACTICE	YEAR	TERM 1 (14 WEEKS)		TERM 2 (14 WEEKS)		TERM 3 (14 WEEKS)	TIME ALLOCATION (WEEKS x HOURS)	
	1			Clinical Practice (2 weeks)	Clinical Practice (2 weeks)			4 x 40 (160 hours)
	2								CLINICAL PRACTICE		14 x 40 (560 hours)
	3	CLINICAL PRACTICE	CLINICAL PRACTICE				26 x 40 (1040 hours)	

Admission requirements

The minimum academic entry requirements for the programme will be the possession of credits in five subjects at General Certificate of Education, Ordinary Level, or the West African School Certificate. Two of the subjects must be passed at General Certificate of Education Advanced Level. The subjects at the GCE 'O' Level or West African School Certificate Level must include English language, and a science subject, preferably biology, physics or chemistry

Applicants must be at least 18 years old at the time they wish to start the programme. It is required that applicants have personal qualities and attitudes required for a health care profession. For example, they need to show that they can handle problems in a mature way and have good judgement in handling any situation. The ability to relate to people is very essential. The applicant needs to be someone with imagination and initiative in the discharge of occupational therapy work. We can seek to meet these requirements through letters of reference from people who are familiar with the applicant, for example, the applicant's school teacher. We can send prepared information to the applicant's referees, asking them to rate the applicant on the specific areas on which we would want information. One important aspect of entry procedure is to reduce wastage. We want to ensure that applicants have sufficient knowledge of the realities of the work of

occupational therapists in the context in which that work takes place, that they are unlikely to be surprised by their experiences in training or work; we need them to be in a position to make a rational commitment to the training and the career.

Therefore, as part of the selection procedure, applicants chosen for final selection will be put in a situation such as visits to departments of occupational therapy, where they will be shown the type of work occupational therapists do, make observations and write a report of their observations. The report must be submitted to the school before the final interview.

Because training and practice of occupational therapy is demanding and concentrated, good health and stamina are required. Each applicant will be required to produce evidence of satisfactory medical fitness.

When necessary, entrance examinations into the programme in the form of, for example, essays and general knowledge tests may be conducted to arrive at the intake number for the year. Applicants will be required to produce documentary and satisfactory evidence of financial support if admitted into the programme.

Only candidates with the minimum admission requirements will be called for interview and considered at the final selection stage.

Method of application

Applications for entry into the programme will be advertised. Application to the programme will be made on a form supplied by the school. Applications will be made to the school one year before the candidates wish to enter the programme.

Annual intake of students

Twenty students will be admitted into the programme each year. A larger intake may be considered later, depending upon the resources available, such as staff, accommodation and placements for clinical practice.

10.3.2 Teaching Methods

Our principles for teaching and learning, stated in Chapter 9, are reflected in Table 10.2 and in the statement of individual courses in the Course Syllabus (Appendix 10).

10.3.3 Staffing

What type and number of teachers do we have to look for? How are we going to use our staff? What should the ratio of staff to students be? The answers to these questions are in our principles on contents, teaching and learning and course structure in Chapter 9. In the discussion, we mentioned that the course will be multi-disciplinary.

TABLE 10.2

Outline of Teaching Methods in the Nigerian Programme

YEAR	COURSE	METHOD	HOURS PER WEEK	INSTRUCTORS
1	Anatomy, Physiology, Kinesiology	Lectures	2	Specialists
		Practicals	1	
		Tutorials	1	Occ. Therapists
	Psychology, Medical Sociology	Lectures	2	Specialists
		Practicals	1	
		Tutorials	1	Occ. Therapists
	Practical Skills in Occupational Therapy	Lectures	2	Occupational Therapists
		Practicals, Group work Tutorials	4	
	OCCUPATIONAL THERAPY THEORY, PRINCIPLES AND PRACTICE	-		Occupational Therapists
	Occupational Therapy Studies 1	Lectures	3	
Tutorials, Practicals, Case Studies, Simulations, Group discussion		3		
Clinical Practice	Observation, Attendance at Seminars, Ward rounds, Discussion		Occupational Therapy Clinical. Instructors	
2	Medicine and Surgery	Lectures	3	Specialists
		Practicals	1	
		Tutorials	1	Occ. Therapists
	Psychiatry	Lectures	3	Specialists
		Practicals	1	
		Tutorials	1	Occ. Therapists
	Practical Skills in Occupational Therapy	Lectures	2	Occ. Therapists
		Practicals, Group work Tutorials	4	
	OCCUPATIONAL THERAPY THEORY, PRINCIPLES AND PRACTICE			Occupational Therapists
	Occupational Therapy Studies 2	Lectures	1	
Tutorials, Practicals, Case Studies, Simulations, Group discussion		5		

Cont'd.

TABLE 10.2 cont'd.

Outline of Teaching Methods in the Nigerian Programme

YEAR	COURSE	METHOD	HOURS PER WEEK	INSTRUCTORS
2	Occupational Therapy Studies 3	Lectures	1	Occupational Therapists
		Project - Staff Discussion with Individual Students		
3	Clinical Practice	Practical sessions, Tutorials, Discussion, Seminars, Case Presentation, Attendance at Ward Rounds, Observing Occ. Therapists at Work	40	Occupational Therapy Clinical Supervisors

We argued for using occupational therapists teaching all the courses but in case this is difficult or impossible will consider non-occupational therapists teaching non-occupational therapy courses. We also said we are going to use diverse teaching methods. Our programme structure and teaching method (Tables 10.1 and 10.2) allow for different people to teach simultaneously in the course. All these make some demand on the resources we may have available.

Other demands on the teachers are the number of students for each year that we are going to take, which we have estimated to be 20 per year.

From these, we can more or less predict the staff demand for our programme. We will require a Head of Programme, who will direct and co-ordinate the affairs of the programme. We will also require a Secretary to be responsible for secretarial and administrative matters relating to the programme.

In the first year, we will require three occupational therapists, two for service teaching of practical skills, professional courses and tutorials in biological and behavioural sciences, and one to assist the head of the programme in organising and arranging students' clinical practice. In the same year, two specialists will be needed for the teaching of biological and behavioural sciences. As students build up, we will require more

staff. So, in the second year, we will require two more occupational therapists, one to teach the application of occupational therapy to medical/surgical conditions and to give tutorials associated with the medical/surgical courses, and the other to teach the application of occupational therapy to psychiatric conditions and to teach tutorials in the psychiatry course. Also, two specialists will be required, one to teach medicine/surgery and the other psychiatry. From the third year, one occupational therapist will be required to assist the head of the programme in the area of general servicing of the programme-evaluation. Since students will spend about two-thirds of their time away from school in third year, this means very little teaching will be done at the school except for reviewing clinical practice with students, which will be a responsibility of staff who organise clinical practice and supervision of students' projects which will be a shared responsibility among all occupational therapy teaching staff.

The tutors (both occupational therapists and non-occupational therapists) will be responsible for teaching their assigned courses, assessing students and developing their courses. Each occupational therapy tutor will be assigned a group of students and will act as counsellor or adviser, and supervise the final project.

The specialists are more than likely to be employed part-time while the occupational therapists will be full-time.

So, our total staff complement will be about twelve. The ratio of academic staff to students over the three years will be about 1:5.

From Table 10.2 the contact time with students, for each of the staff, amounts to seven hours per week for occupational therapists and three and four hours per week in first and second years respectively for the specialists.

10.3.4 Resources

The location of the school gives the programme certain advantages in terms of resources for teaching and learning and for recruiting specialists to teach on the course. This is because the school is located in a city (Kano) which has a university with a medical school, a university teaching hospital, an orthopaedic hospital with a department of occupational therapy, a general hospital, a psychiatric centre, many private health clinics and a range of higher education centres.

Accommodation

The accommodation for the programme, in terms of offices, classrooms, lecture halls, workshops, library, staff room, gymnasium, students' common and changing rooms, store room and cafeteria, have been constructed even before this study was commenced. The programme will be sharing some facilities,

for example, the library and lecture theatres, with the existing physiotherapy programme.

Equipment and materials

We have to have certain equipment and materials to cope with the variety of teaching methods we are proposing. Also the types of equipment and materials we require will depend upon the practical skills we will teach in the programme. It is therefore difficult in this thesis to spell out in detail what our requirements will be. We will look at the issue from the angle of what is available in Nigeria, what we can locally produce ourselves, and what is absolutely essential for us to import from overseas. We already have a picture of our student intake number, which will help us to further determine our requirements. Our choice must also reflect the skills of our teachers in using the teaching equipment we choose.

Finance

The Nigerian Government will provide the funding necessary for running the programme, covering staff salaries, equipment and materials. Again, it is difficult and will be unwise to provide costing for the programme in this study, because firstly, at the moment, the Nigerian economy is unpredictable and prices are unstable, and secondly, economic conditions may change. What will be

necessary is to plan the financial requirement for the initial take-off for the first year of the programme and after that provide an annual budget for running the programme.

Selection of placements for students' clinical practice

The students' clinical practice will take place throughout the country in hospitals with occupational therapy departments. The placements will be selected on the criteria that:

1. The placement has at least two qualified and experienced occupational therapists.
2. The occupational therapists are willing to supervise students.
3. The placement can offer students a range of experience or experience of a specialised nature.

A student's request for a particular placement in a particular location can only be considered if the school is satisfied that the student will get adequate supervision.

10.3.5 Assessment of Students' Performance

The principles for assessing students' performance in the course are reflected in Table 10.3 and statements in individual courses in the Course Syllabus (Appendix 10).

TABLE 10.3

Outline of Methods of Assessing Students' Performance in
the Nigerian Programme

COURSE	TECHNIQUES	
Anatomy, Physiology Kinesiology	1 test middle of each term 1 test end of 1st, 2nd term	Essays, short notes, multiple choice, practicals
	1 end of course final exam	" "
Psychology	1 test middle of each term 1 test end of 1st term 2 assignments	Essays, short notes, assignments
	1 end of course final exam	" "
Medical Sociology	1 test middle of term 1 assignment	Essays, short notes, assignments
	1 end of course final exam	" "
Medicine & Surgery, Psychiatry	Each course will have 1 test middle of each term 1 test end of 1st term 2 assignments	Essays, short notes, multiple choice, assignments
	1 end of course final exam	" "
Practical Skills	Folio compilation Completion of assigned project	
	End of course exam	Practical oral exam & presentation
Theories, Principles & Practice of Occ. Therapy	1 test middle of each term 1 end of term test Assignments	Essays, short notes, practical viva.
	End of course final exam	" "
Clinical Practice	Each clinical practice will be assessed half- way and at the end of practice	Oral viva, written reports from clinical supervisors. Completion of assigned folio project and required number of hours.

Probation

The first term of the programme will be a probationary period, at the end of which the training may be terminated if the student has been unable to maintain the required standard of work.

Record of assessment

Each student's assessment record will be kept, containing all assessment reports and records of marks obtained.

Students' progression and consequences of failure

Students' progression in the programme will depend upon successfully attaining the required standards. All courses must be passed before progression to the next stage of the course. Opportunities will be given for one re-sit examination. Failure in the re-sit will result in discontinuing the student from training.

Marking system

The grading system adopted throughout the course will be on a pass or fail basis.

At the end of the training, the degree will be awarded only to students who have successfully:

1. Passed all course work.
2. Passed all practical skills.
3. Passed all clinical practices and completed the required number of hours.
4. Completed and passed a research project in a topic relevant to occupational therapy.
5. Passed the final written and oral examinations.

10.3.6 Monitoring the Programme

In monitoring the programme, it is required that there should be consultation between staff, between staff and clinical supervisors, and between staff and students. These can be achieved through a series of meetings and committees.

Staff consultation

Regular faculty staff meetings will provide the opportunity for discussion about the programme, professional matters and students' performance and guidance. Periodic meetings are also necessary between the faculty staff, clinical supervisors and specialists teaching on the course to provide an opportunity for discussion about the programme, the courses and students' clinical practice.

Staff-student consultation

This will provide an opportunity for discussion between

faculty staff and students on all aspects of the course and its organization.

Occupational therapy academic committee

This committee shall consist of the head of the programme and all occupational therapy faculty staff. The committee will be responsible for:

1. The maintenance of standards in the programme.
2. The selection of students into the programme.
3. The organization of assessments in the course, for example, approving frequency of assessments, question papers, marking of examinations, pass or fail marks, drawing up examination time-tables, referral of students for re-sit examinations.
4. Disciplinary matters.
5. Recommendations to the head of the programme regarding the award of the degree and matters arising under points 1-4 above.

In this chapter, we have devised a curriculum plan for the training of occupational therapists in Nigeria, using the principles identified in Chapter 9.

CHAPTER ELEVEN

CONCLUSION

The main purpose behind this study has been to produce a curriculum plan for the professional education of occupational therapists in Nigeria. When the plan is put into operation it will be a contribution to the efforts of the Federal Government of Nigeria to increase the supply of health manpower and to provide Nigerians with a comprehensive health programme.

11.1 Discussion

Throughout the length of this study, the discussion and the evidence gathered suggest that there is no single, right answer to planning a curriculum. This study provides a particular approach to the design of a curriculum for training occupational therapists in a particular setting. The study could not draw to any extent upon past research on curriculum planning in occupational therapy itself because such evidence was very limited. Instead, the study has drawn upon various other sources:

1. Evidence gathered from Nigerian occupational therapists, study of occupational therapy situations and practices in Nigeria, information available on health in Nigeria, as well as circumstances particular to Nigerian society.

2. General curriculum models and issues in professional education.
3. Information on the training of occupational therapists from the profession's international body, other countries including the United Kingdom, and the practical study of experiences of those who are involved in occupational therapy training in Scotland.
4. The writer's knowledge and experience of occupational therapy and of Nigeria were also sources drawn upon.

These sources have given the proposed curriculum its characteristics.

11.2 Continuing Issues in Planning a Curriculum for Professional Education .

As stated in 11.1, there is a lack of any theoretical model on which the planning of an occupational therapy curriculum might be based. The discussion of professional education in Chapter 3 suggests that models have changed from ones based on 'apprenticeship' to ones based on theory plus practice, and further, to ones emphasising grounded theory derived from practice. In thinking about the problem of developing an occupational therapy curriculum for Nigeria, I have not created a general model, but have become aware of general issues which any model or theory

would have to deal with. First, there must be a clear idea of the kind of graduate who is to be produced: the competent professional occupational therapist. In planning the curriculum, the skills, knowledge and attitudes needed by this imaginary person are central. And he or she must be guided to the situation in which his or her work will be carried out, and so, to the needs of the clientele. This may create conflict in curriculum planning, because the needs of one country may not indicate the same priorities as the worldwide literature suggests.

This idea of the abilities needed by the competent professional was important in deciding on the balance of medical and occupational therapy knowledge to be included and in the kind of assessment system planned.

Second, there is a need to consider carefully the relative importance of the two main kinds of knowledge, medical and occupational therapy knowledge, taught in the programme, and how they can best support one another. The amount of medical knowledge taught, and the fact that it is taught first, seems to be derived from tradition, rather than a clear theory of how a student's knowledge is to develop.

Furthermore, a model for planning an occupational therapy curriculum would have to consider how the students' induction into the profession's clinical practice would fit alongside their learning of specific knowledge and skills

within the school based programme. These two kinds of learning are rather different, and the role of the student needs to be made clear in each case. In the present study, a practical solution was sought in the way that clinical experience was fitted in at different stages of the course. These issues seem to be important and continuing ones for curriculum planning in professional training generally.

11.3 Monitoring the Curriculum Plan in Action

Evaluation is seen as a vital part of curriculum planning. It can provide us with essential information and permit curriculum changes or modifications when it appears necessary. I plan to monitor the programme on a regular basis through formal and informal means:

1. An occupational therapist in the programme will be employed solely to assist the head of the programme in monitoring the programme.
2. There will be consultation with staff and students in the programme and with our professional colleagues in the community in Nigeria.
3. A non-occupational therapist as an independent individual will be invited to act as external evaluator of the on-going programme.

4. The Nigerian Association of Occupational Therapists and the World Federation of Occupational Therapists will be invited to evaluate the programme.

As well as a general monitoring of the programme, there are a number of areas where close attention may be needed. There are ones suggested in the course of my study, either because I found it difficult to decide what should be done and so would welcome further information, or where problems have been encountered for example in the United Kingdom case studies. One area to be monitored will be that of student performance (and any) wastage. We want to know whether our measures for selection and checking progress are satisfactory, and whether any students who drop out represent possible weaknesses in the programme. Each case of failure at particular points of the programme or drop-out should therefore be investigated fully to see whether they could have been prevented, and the procedures improved. This could be done by the occupational therapist mentioned under (1) above.

No student should fail unnecessarily. Equally, no student should pass who is not suited to the occupational therapy profession. We should carry out follow-up studies of all graduates to face their careers after graduation. This will help us to check whether our training programme is serving the needs of the country and whether

our graduates find it easy to cope with 'real life' practice. The continued consultation, under (2), will assist this.

The examinations and other assessments will be used not just to award qualifications, but to gather information about students' strengths and weaknesses, and a report on this will be fed back to the staff teaching various courses. The continued consultation, under 1-4, will assist this. The assessment procedures themselves will, hopefully, be continuously improved with experience.

A particular problem may arise with the outside specialists brought in to teach in the programme. As suggested in Chapters 9 and 10, their contribution will be monitored by means of consultation and policy.

Finally, it will be important to monitor the use of resources; not only equipment and accommodation, but the use of staff and student time. The proportion of time spent on different activities and courses are to a large extent a guess, based on precedent and experience, and partly reflecting the importance of each, as much as any real measure of how long it takes to complete units and activities properly. We would want to review the timetable regularly and perhaps ask students and staff to keep a note of how they spent their time during selected sample periods. These will be assisted by continued consultation under 1-3 .

11.4 Further Research

Monitoring is the process of ensuring that the programme achieves its intended goals and runs smoothly. However, we need also to consider how the goals of the programme themselves might be developed and changed in the longer term. Given the slender amount of evidence available at the time of planning the programme, more research is indicated on the changing needs of Nigerian society, and the roles that occupational therapists do, or might, play in that society. For example,

1. What has been done in this study is to have a checklist of methods occupational therapists use in Nigeria. There will be a need for deeper analysis of how the occupational therapists use the various methods and how the occupational therapists use local resources in providing their service. This in future will go further towards knowing what knowledge and skills to emphasise in our programme.
2. We will need to know more about other areas in which the profession can give service, in addition to the present hospital-based practice, the population they are not serving, how the occupational therapists can be utilised more in the community, and finding out about injuries not getting to the occupational therapists. The country should be reviewing these

areas and the profession should rely on a general research strategy.

3. Also, we do not know at present about future health problems that may arise in Nigeria and to which trainees will need to address themselves. This is something worth looking into in the future. We should be able to study trends in national medical statistics, and, if need be, collect supplementary statistics, to predict demand both in quantity and kind.
4. We may also consider the possibility of developing auxiliary workers to assist with occupational therapists, for example, in ensuring that patients carry out their activities while the occupational therapist is elsewhere. These auxiliaries might then be recruited into a training programme later on.
5. We may also want to know how other professions similar to occupational therapy such as physiotherapy, train their professionals in Nigeria. A comparative study may be useful to our programme.
6. Research on patients themselves, especially on their attitudes towards the treatment they get, may suggest changes in our programme.

7. A further point is related to the public awareness of occupational therapy - a public relations exercise. For example, occupational therapy will not be used if people are not aware of it, and so may not be funded and promoted by the Government if there is no pressure to provide it.

The evidence from these areas of further research may be helpful to our programme. In which case we may have to make modifications to our programme. This should not be too difficult to do since the programme will already have a foundation of experience to build upon.

REFERENCES

REFERENCES

- ABRAHAMSON, S. Professional Education
Review of Educational Research, Vol.35,
pages 335-346, 1965.
- BARROW, R. Giving Teaching Back to Teachers.
A Critical Introduction to Curriculum
Theory.
Wheatsheaf Books Ltd., Sussex, 1986.
- BASSAN, L., Occupational Therapy: The Basic Concept
ALFIERI, V. Behind the Conventional Team.
The British Journal of Occupational
Therapists, Vol. 46, No.10, page 285,
October 1983.
- BLIGH, D.A. What's the Use of Lectures?
Penguin Books Ltd., Harmondsworth, 1971.
- BLOOM, B.S. et al. Taxonomy of Educational Objectives
David McKay Company, New York, 1956,
1964.
- BROWN, J. Committee Secretary (Education)
College of Occupational Therapists,
London, May 1985.
- COHEN, L., Research Methods in Education.
MANION, L. Croom Helm Ltd., St John's Wood,
London 1980, page 247.
- COLLINS English Dictionary
William Collins Sons & Co., Glasgow 1984.
- DINHAM, S.M. Research on Professional Education
STRITTER, F.T. Third Handbook of Research on Teaching
Edited by Wittrock, M.
Macmillan Publishing Co. 1986, pages
952-970.

EDWARDS, J.D. Occupational Therapy Role and Function. MSc Thesis, Department of Community Medicine, University of Manchester 1980.

Federal Republic of Nigeria - 1980 Summary of Hospitals Morbidity and Mortality by Groups of Diseases, According to the International Classification of Diseases (8th Revision). Medical Statistics Division, Federal Ministry of Health, Federal Secretariat, Ikoyi, Lagos, Nigeria, 1980.

Federal Republic of Nigeria: Guidelines for the 4th National Development Plan 1981-1985. The Federal Ministry of National Planning, Lagos.

GAY, L.R. Education Research Competencies for Analysis and Application. Charles E. Merrill Publishing Company, Columbus, Ohio, 1976, page 137.

GOODLAD, S. Professional Interests Deepen. The Times Higher Education Supplement, London, September 14, 1984, page 15.

GOLDENBERG, K. Occupational Therapy Today: A Changing Profile. Guest Editorial: National Canadian Association of Occupational Therapists, November 1984.

Handbook for Candidates who Wish to Commence Training in Autumn 1985. Occupational Therapy Training Clearing House, College of Occupational Therapists, London.

Health Manpower in Nigeria: 1976 to 1983 Medical Statistics Division, Federal Ministry of Health, Federal Secretariat, Ikoyi, Lagos, Nigeria.

Health Services Facilities in Nigeria, 1971, 1976 to 1979 Medical Statistics Division, Federal Ministry of Health, Federal Secretariat, Ikoyi, Lagos, Nigeria, 1981.

HIRST, P.H. Towards a Logic of Curriculum Development. In The Curriculum: Research, Innovation and Change Editors: Taylor P, Walton, J. Ward Lock, London 1973.

HIRST, P.H. Knowledge and the Curriculum Routledge and Kegan Paul, London 1975.

- JENKINS, D.,
SHIPMAN, M.D. Curriculum: An Introduction.
Open Books Publishing Ltd., London
1976, page 96.
- KERR, J. The Problem of Curriculum Reform.
In Changing the Curriculum
University of London Press, London, 1968.
- LAWTON, D. Curriculum Studies and Educational
Planning.
Hodder & Stoughton, London 1983, page 1.
- MacDONALD, E.M. Occupational Therapy in Rehabilitation
2nd Edition, Bailliere Tindall Company,
London, 1976.
- MAIDEN, D. Chairman, Standing Committee on Education,
Australian Association of Occupational
Therapists, Melbourne, Australia,
March 1985.
- MAYHEW, L.B. Changing Practice in Education for the
Professions.
Southern Regional Educational Board,
Atlanta, Georgia, 1971.
- Members' List. The Nigerian Association of Occupational
Therapists, Lagos, Nigeria, 1982.
- MERRIT, J. A Framework for Curriculum Design,
Unit 10, E.283. The Curriculum,
Bletchley, Open University Press, 1972.
- NICHOLLS A.,
NICHOLLS, S.H. Developing a Curriculum.
A Practical Guide
George Allen and Unwin, London 1978,
pages 20-30.
- OGAWA, K. Secretary - Treasurer, Japanese
Association of Occupational Therapists Inc
Tokyo, Japan, February 1985.

- OGUNSEITAN, S. Nigerians May Live Five Years Longer. The Guardian Newspaper, Lagos, Nigeria, January 25, 1985.
- OPPENHEIM, A.N. Questionnaire Design and Attitude Measurement. Heinemann Educational Books Ltd., London, 1984, page 31.
- OSIKOYA, F.O. Factors Related to Grade Distribution in Four Basic Occupational Therapy Courses. M.A. Thesis, University of Alabama in Birmingham, Birmingham, Alabama, U.S.A., 1980.
- PAATERO, S. Physiotherapy in Future Prospect - An Idea of Reality. IXth World Congress of Physiotherapy Proceedings, Part II: pages 868-877, 1982.
- POPHAM, W.J. Objectives '72' In Curriculum Handbook: The Disciplines, Current Movements and Instructional Methodology. Allyn and Bacon, Boston, 1977.
- PRESELLER, S. Director, Education Department, American Occupational Therapy Association, Inc., Rockville, Maryland, U.S.A., December 1984.
- Recommended Minimum Standards for the Education of Occupational Therapists, World Federation of Occupational Therapists, 1984.
- SHIPMAN, M. Contemporary Analysis in Education Series Education Research: Principles, Policies and Practices. The Falmer Press, London 1985, page 65.

- SKILBECK, M. School-Based Curriculum Development. Planning in the Curriculum. A Reader edited by Victor Lee and David Zeldin for the Purpose and Planning in the Courses at the Open University. Hodder and Stoughton, in association with The Open University, 1982.
- SOCKETT, H. Designing the Curriculum
Open Books. London 1976, page 23.
- SPACKMAN, Willard, R. Occupational Therapy. Fourth Edition, J.B. Lippincott Company, Philadelphia.
- STENHOUSE, L. Some Limitations of the Use of Objectives in Curriculum Research and Planning, Pedagogica Europa, 1970, Vol.6, pages 73-83.
- STENHOUSE, L. An Introduction to Curriculum Research and Development.
Heinemann, London, 1984.
- Summary of Road Accidents in Nigeria, showing Number of Reported Cases and Persons Involved from 1970 to 1978.
Federal Office of Statistics, Lagos, Nigeria, 1978.
- SYM, D. Alternative Model for Basic Education: College Diploma Course. Proceedings World Federation of Occupational Therapists, 6th International Congress. Vancouver, British Columbia, Canada, August 12-16, 1974, pages 566-573.
- TABA, H. Curriculum Development: Theory and Practice.
Harcourt Brace and Ward, New York 1962, page 197.
- THACKERAY, G. Alternate Delegate to World Federation of Occupational Therapists
Verband der Beschäftigungs-und-Arbeitstherapeuten (Ergotherapeuten) e.V
Munchen, Federal Republic of Germany, February 1985.

The Structure of the Curriculum in the Third and Fourth Years of the Scottish Secondary School, Scottish Education Department, Consultative Committee on the Curriculum, HMSO, Edinburgh 1977.

TYLER, R.W. Basic Principles of Curriculum and Instruction, University of Chicago Press, Chicago 1949.

Validation Board Manual (amended 21st May 1984)
College of Occupational Therapists, London 1984.

VANDERMAN, H. Nationally Speaking: Rehabilitation International Charter for the 80's. The American Journal of Occupational Therapists., Vol.34, No.10, pages 645-647, October 1980.

West African Correspondent, West Africa Magazine, page 1290
24th June 1985. West Africa Publishing Company, London 1985.

WILLENSKY, H. The Professionalisation of Everyone
American Journal of Sociology,
Vol.70, 1964, pages 137-158.

WOODSIDE, H. Basic Issues in Occupational Therapy
- Education Today. Paper Delivered
to the Occupational Therapy Section,
Ontario Hospital Association Meeting,
October 29, 1975.

BROCHURES: OCCUPATIONAL THERAPY NATIONAL ASSOCIATIONS

Diploma Course 1981. Training in Occupational Therapy,
College of Occupational Therapy, London 1981.

Essentials and Guidelines of an Accredited Educational Programme for the Occupational Therapists.
The American Occupational Therapy Association Inc.,
Rockville, Maryland, U.S.A., 1983.

Manual for the Diploma Course and Examination of
the College of Occupational Therapists,
College of Occupational Therapists, Revised March 1979.

Standards for the Education of Occupational Therapists
in Canada. The Canadian Association of Occupational
Therapists, Toronto, Ontario, Canada, 1980.

PROSPECTUSES/BROCHURES: OCCUPATIONAL THERAPY SCHOOLS IN THE U.K.

Prospectus: Derby School of Occupational Therapy.

Diploma of the College of Occupational Therapists
(Abridged Version), The College of Ripon and York, St John,
1984.

Diploma 1981. Outline Submission of Proposed Course,
The Dorset House School of Occupational Therapy, Oxford.

Diploma in Occupational Therapy,
Queen Margaret College, Department of Occupational Therapy,
1984/85.

Occupational Therapy,
Salford School of Occupational Therapy, Salford College of
Technology.

Occupational Therapy Diploma '81. Outline Submission
Department of Occupational Therapy and Physiotherapy,
Faculty of Social and Health Sciences,
University of Ulster, August 1984.

Outline Submission
The Welsh School of Occupational Therapy, March 1984.

Outline for a Three-Year Course leading to the Diploma
of the College of Occupational Therapists,
School of Occupational Therapy, St Andrews Hospital,
Northampton.

Proposed Submission of a full-time Course leading to the
Award of a Diploma in Occupational Therapy.
Newcastle-Upon-Tyne Polytechnic, School of Health Studies.

Prospectus 3 Year Diploma Course.
The College of Occupational Therapy (Liverpool) Ltd.

Validation Submission Parts 1 & 2,
Grampian Health Board, Grampian School of Occupational
Therapy. Revised September 1984.

APPENDICES

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APPENDIX 1THE LETTER OF OFFER OF A POST-GRADUATE SCHOLARSHIP AWARD,
FEDERAL GOVERNMENT OF NIGERIA.

FME/SCH/30



FEDERAL REPUBLIC OF NIGERIA

FEDERAL MINISTRY OF EDUCATION
SCHOLARSHIPS DIVISION, LAGOS

FEDERAL GOVERNMENT SCHOLARSHIPS PROGRAMME

P.M.B. 12573

Telegrams : SECEDUCATE

Ref. ED/SC /PG/82/01408/10

Telephone 633080

17th February, 1983

Mr/Mrs/Ms/Dx ~~FRANCIS OLATOKUNBO O. OSIKOYA~~

OFFER OF PROVISIONAL AWARD OF POST-GRADUATE

SCHOLARSHIP FOR 1982/83

OVERSEAS INSTITUTIONS

1.—(i) With reference to your recent application for the above Award, I have pleasure to inform you that you have been made a provisional offer of an Award by the Federal Government of Nigeria to enable you to study for a course in OCC. THERAPY leading to PH.D qualification

2. The Scholarship is tenable in OVERSEAS and takes effect from the beginning of the 1982/83 academic session. It lapses if not utilised by the 1st of October, 1983 Within this period you are expected to acquire the requisite university/institutional admission qualification for the course of your Award where it is tenable, if you do not already have it, to enable you make use of the Award.

3. This Award shall not be held at the same time with another award.

4. Your Award shall only be confirmed on the presentation or submission to the Secretary, Federal Scholarships Advisory Board, or other authorised officers of the Federal Ministry of Education, Lagos, of the ~~original~~ of your degree certificate and/or diploma and other relevant certificates.

5. You are not to change your course or the place of your Award without the prior approval of the Federal Scholarships Advisory Board. If you do so your Award shall be withdrawn from you and if any sum of money had been expended on you for the unauthorised course by the time of discovery, you and or your guarantors will be called upon to refund it to the Federal Government of Nigeria.

6. The Board is under no obligation to change the course, venue or qualification of your award, especially in order to enable you utilise it before the expiration of the two-year period of grace as stated at 2 above. Applications for changes of courses, venues, or qualifications of awards will therefore be entertained only in exceptional cases.

7. No payment shall be made in respect of your Award without your satisfactorily and properly executing your Bond as well as your guarantors completing their forms and satisfying other conditions of the guarantee. You are therefore advised to execute your bond quickly to avoid any hardships in connection with your course.

8. If you are employed, or under obligation to someone or some organisation, you are required to submit a letter from your employer or that organisation stating :

(i) that you are free to take up your Award ; or

(ii) that you have been granted leave to take up your Award ; or

(iii) that you are not indebted to your employer ; or if you are, that you have been released to take up this Award.

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copy

9.—(i) You are not to undertake your journey abroad for your course without prior notification and approval of the Scholarships Division of the Federal Ministry of Education, Lagos.

(ii) No refunds of fares for journeys undertaken before the announcement of your Award shall be made.

10. Your Scholarship entitles you to the payment of your :

(i) Tuition fees ;

(ii) Maintenance Allowance (including books and equipments) at the following rates :

(a) U.K. and Europe (except Paris and Bonn)	.. .. N 280	per month
(b) U.S.A.	.. .. N	per month
(c) Canada	.. .. N	per month
(d) Australia	.. .. N	per month
(e) West Africa	.. .. N	per month
(f) North Africa	.. .. N	per month
(g) Paris	.. .. N	per month
(h) Bonn	.. .. N	per month

(iii) Travel Allowance in (U.K. and Europe, Australia and Canada)	.. .. N 120	per annum
U.S.A.	.. .. N	per annum
West Africa	.. .. N	per annum

(iv) Return Air or Sea passage at economy rate.
v fees for thesis once during the course #200

11. If you were single at the time of this Award, you are not to marry without prior approval by the Federal Ministry of Education. If you marry even with the approval, or you were married before the Award, the Federal Government shall not accept any responsibility, financially or otherwise, resulting from your marriage. This Award also carries no responsibility in any form towards your dependants.

12. If you accept the offer, please complete the forms/documents as listed below and return them immediately to the Permanent Secretary, Federal Ministry of Education, Scholarships Division, Lagos.

The forms/documents are :

(i) A Letter of Acceptance.

(ii) Bond forms in duplicate.

(iii) Guarantors forms and Certificate of medical fitness to undertake your course of studies. You are also required to forward along with your medical certificate an X-Ray film of your chest. (X-Ray film 15cm x 10cm is preferred please).

Note.—Those who have been tested and found medically fit to undertake their courses abroad by the appropriate medical authority of their institution may submit the medical certificate or report issued to them by the authorised medical officer in this respect in lieu of 12 (iv) above.

I am Sir/Madam,
Your Obedient Servant,

M. Y. Katagum
M. Y. Katagum (Mrs.),
for Permanent Secretary,
Federal Ministry of Education

Mr. Francis Olatokunbo O. Osikoya,
Department of Occupational Therapy,
National Orthopaedic Hospital,
P. M. B. 3087,
Dala - Kano, Kano.

UNIVERSITY OF STIRLING STIRLING FK9 4LA SCOTLAND | Telephone: STIRLING (0786) 73171
Telex: 777759 STUNIV G

APPENDIX 5A

THE LETTER WHICH ACCOMPANIED THE QUESTIONNAIRE TO NIGERIAN
OCCUPATIONAL THERAPISTS

Dear Colleague

I am writing to you to request your assistance in completing the attached questionnaire on the matter of the professional education of occupational therapists in Nigeria.

I understand that the Federal Ministry of Health intends that in future occupational therapists in Nigeria should receive their initial professional education within the country rather than overseas. I am currently on leave of absence from my employment as Principal Occupational Therapist at the National Orthopaedic Hospital, Kano, and I have been awarded a two (2) year scholarship by the Federal Government of Nigeria so that I can plan carefully, a programme for the initial professional education of occupational therapists in Nigeria. I am doing the planning work as a postgraduate student in the above university and I will be presenting my plans to the Federal Ministry of Health on my return to Nigeria in September 1986.

While I shall be taking full account in my planning of the practices of professional education programmes for occupational therapists offered in other countries such as United Kingdom, I am concerned to ensure that the programme I plan will be well suited to the Nigerian context. In addition I am concerned that it should have the support of practising occupational therapists in Nigeria. For these two reasons, I consider that the knowledge and the views of practising occupational therapists in Nigeria are major sources of ideas to influence my planning.

As part of my present studies I wish to obtain the fullest possible information from all occupational therapists practising in Nigeria. In order to indicate more fully the matter on which I am seeking your assistance, the questionnaire has been divided into three parts.

In part one the questionnaire is seeking *facts on the current situation* with regard to the practice of occupational therapy in Nigeria. I want to get as clear a general picture as possible of what occupational therapy work in Nigeria involves at present. Therefore, I am asking you about, for example, the type of hospital in which you are working, who refers patients to you, whether you are working in a specialist area within occupational therapy, the type and frequency of diagnosis referred to you and the main methods of occupational therapy you use in treating your patients.

In part two, the questionnaire is seeking *opinions on occupational therapy issues in Nigeria*. I would like my planning to take account not only of what is happening at present, but also of how professional colleagues think the planning should develop.

In part three, the questionnaire is seeking *opinions on an appropriate occupational therapy training programme for Nigeria*. I should be interested in ideas you may have about training methods to use, contents to be included and objectives to be emphasised.

Your/

Page 2

Your response to this questionnaire will be attended to most carefully in my planning of the training programme for occupational therapists in Nigeria and I shall be most grateful for your help in completing the attached questionnaire.

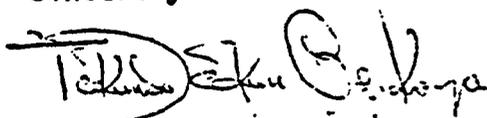
In order that I can take full account of your ideas, it is important that the completed questionnaire be returned to me before MAY 30 1985.

I enclose a self-addressed envelope and apologise for my inability to provide Nigerian stamps for the return postage.

I look forward to receiving your completed questionnaire.

Thank you.

Sincerely

A handwritten signature in dark ink, appearing to read 'F O Osikoya', written in a cursive style.

F O Osikoya
Postgraduate Student
Department of Education
University of Stirling

Enc:

APPENDIX 5B

THE QUESTIONNAIRE SENT TO NIGERIAN OCCUPATIONAL THERAPISTS

PART 1

This section of the questionnaire is seeking facts on current occupational therapy practising situation in Nigeria.

(a) Type of hospital or other health unit you are currently employed.

Please tick ✓ one that is appropriate.

- Teaching hospital.
- General hospital.
- Specialist hospital- Orthopaedics.
- Psychiatry.
- Tropical diseases.
- Other (please specify)
- Military hospital.
- Private hospital or Clinic.
- Rehabilitation centre.
- Other kind (please specify).

(b) Source of patients' referral to your occupational therapy department.

Please tick ✓ those that are appropriate.

Sources Of Patients' Referral

	Often	Occasional	Never
Your hospital, from individual doctors.	Generally more than once per week	Generally less than once per week	
Your hospital, from grand ward rounds.			
Your hospital, from rehabilitation departments e.g. physiotherapy..			
General Practitioners.			
Rehabilitation Centres.			
Patients' employers.			
Other source (please specify)			

(c) Are you working in a specialist position within occupational therapy?

Please tick

YES
NO

 if YES. please tick your area of specialism below.

Psychosocial conditions.

Physical conditions (General Medical Conditions).

Orthopaedics/Surgical conditions.

Paediatrics/Neuro-developmental conditions.

Neurological conditions.

Tropical diseases .

Other conditions (please specify).

(d) For each of the types of diagnosis listed below, please indicate with a tick ✓ the frequency of cases referred to you as a part of your individual case load.

Frequency Of New Referral

	Often Generally more than once per week	Occasional Generally less than once per week	Never
<u>Psychosocial Conditions</u>			
Neurotic disorder			
Psychotic disorder			
Personality disorder			
Organic states			
Drug/alcohol abuse			
Mental subnormality			
Other (please specify)			

Physical Conditions (General Medical Conditions)

Diseases of cardiovascular system			
Diseases of respiratory system.			
Diseases of urogenital system.			
Diseases of endocrine system.			
Diseases of locomotor system .			
Diseases associated with ageing.			
Other (please specify).			

Frequency Of New Referral

	Often	Occasional	Never
	Generally more than once per week	Generally less than once per week	
<u>Orthopaedics/Surgical Conditions.</u>			
Fractures and dislocations.			
Amputations.			
Tissue injuries e:g.muscles, tendons, ligaments.			
Burns			
Arthritis.			
Joint and bone diseases.			
Hand injuries.			
Other (please specify).			

Paediatrics/Neuro-developmental Conditions.

Diseases of Learning disorder.			
Diseases of developmental disorder.			
Congenital deformities.			
Other (please specify)			

Neurological Conditions.

Cerebro Vascular Accidents.			
Head Injuries.			
Peripheral nerve injuries			
Spinal cord injuries.			
Other (please specify).			

Conditions associated with tropical diseases which require occupational therapy.

Malaria.			
Leprosy.			
Small pox.			
Other (please specify).			

Other Conditions (Please Specify)

PART 2

This section of the questionnaire is seeking your opinions on occupational therapy issues in Nigeria. Please reply to these questions as fully as possible.

- (a) In your judgement, are there health problems in Nigeria which could benefit from occupational therapy services but for which we do not at present have adequate provision?. Please list any such problems.

(b) In order that the occupational therapy profession can make its full contribution to meeting the health needs of Nigeria, what further developments do you believe to be necessary e.g.

The extent to which the profession should expand.

The kinds of skills which the profession needs to develop more fully.

Different kinds of provision there might be in enabling the profession to do its job better e.g. more varied places for therapists to work, more technical support staff, more or better equipment.

PART 3

This section of the questionnaire is seeking your opinions on an appropriate occupational therapy training programme for Nigeria . Please reply to these questions as fully as possible.

(a) From your experience as an occupational therapist, what do you think was neglected in the following aspects of your own training-the THEORY, TECHNIQUES and CLINICAL content of the programme and the teaching methods employed in the programme.

What was excluded that you would have found useful?.

Also, what if anything, was included in your training that you have never found useful?

(b) As an occupational therapist working in Nigeria, have you found that your training failed in any way to prepare you for the distinctive health problems which you have had to deal with in Nigeria?

- (c) Are there any methods of training that you have found particularly helpful, either arising from your experience as a trainee occupational therapist or from your subsequent professional experience that you would recommend for inclusion in a training programme for Nigeria?

- (d) Please give your views on the ways in which the different parts of the training programme should be related to one another e.g. the way in which theory, clinical practice and technical training should be related, the order in which different parts of the training are taught and what the balance of time given to each part should be.

(e) Do you have any further comments which you think might help me in the planning of a training programme? e.g. questions of control, finance, student assessment.

THANK YOU.

UNIVERSITY OF STIRLING STIRLING FK9 4LA SCOTLAND | Telephone: STIRLING (0786) 73171

Telex: 777759 STONIN G

APPENDIX 5C

THE FIRST LETTER OF REMINDER TO NIGERIAN OCCUPATIONAL THERAPISTS

1 July 1985

Dear

In March, 1985, I wrote to you and to all practising occupational therapists in Nigeria enclosing a questionnaire concerning my work in planning the professional education of occupational therapists in Nigeria.

My record shows that, so far, I have not received from you a completed questionnaire. Therefore, because I consider your views and opinions very important in this research, and for the future of occupational therapy professional education in Nigeria, I am sending you this letter of reminder.

In order for me to be able to take full account of your ideas in my planning of the training programme for occupational therapists in Nigeria, it is very important that I receive your completed questionnaire very soon.

In case my first letter did not reach you, please find enclosed a new copy of the questionnaire for you to complete and return to me. I also enclose a self-addressed envelope and apologise for my inability to provide Nigerian stamps for the return postage.

I look forward to receiving your completed questionnaire.

Thank you.

Sincerely



F.O. Osikoya
Post Graduate Student
Department of Education
University of Stirling
Stirling FK9 4LA
Scotland.

UNIVERSITY OF STIRLING STIRLING FK9 4LA SCOTLAND | Telephone: STIRLING (0786) 73171

Telex: 777759 STUNIV G

APPENDIX 5D

THE SECOND LETTER OF REMINDER TO NIGERIAN OCCUPATIONAL THERAPISTS

25 October 1985

Dear Colleague

I wrote to you and to all practising occupational therapists in Nigeria enclosing a questionnaire concerning my work in planning the professional education of occupational therapists in Nigeria.

I have received substantial numbers of replies but thought I would write again to you because I would like to take advantage of your replies in my planning and your particular views would be most helpful.

I am enclosing a self-addressed envelope for return postage and sorry to say that I have made several possible efforts to provide stamps and or other means for return postage but have not been successful.

I look forward to receiving your completed questionnaire.

thank you

Sincerely

F O Osikoya
Post Graduate Student
Department of Education
University of Stirling
STIRLING FK9 4LH
Scotland

THE LETTER WHICH ACCOMPANIED THE QUESTIONNAIRE TO THE WORLD
FEDERATION OF OCCUPATIONAL THERAPISTS

UNIVERSITY OF STIRLING STIRLING FK9 4LA SCOTLAND | Telephone: STIRLING (0786) 73171
Telex: 777759 STUNIV G

Mrs J Barker
11 Slalom Drive
Wembly
Perth 6019
W. AUSTRALIA

Dear Mrs Barker

I am writing to you to request your assistance on the matter of the professional education of occupational therapists. I am currently on leave from my post in the occupational therapy service in Nigeria, doing post-graduate studies in preparation for my return to Nigeria when I shall assume responsibility for the provision of professional education for occupational therapists throughout the country.

As part of my present studies, I wish to obtain the fullest possible information on professional education in various countries. I am writing to each of the national associations of occupational therapists which are members or associates of the World Federation of Occupational Therapists seeking information on positions adopted by them regarding the professional education of occupational therapists. However, it is clearly of primary importance that I should be fully informed about the position of the World Federation of Occupational Therapists itself on all such matters.

I should therefore be most grateful if you could let me have any relevant publication of the World Federation and also any further information which you could supply.

In order to indicate more fully the matters on which I am seeking your assistance, I have attached to this letter a more extended outline.

I look forward to hearing from you and shall be very grateful for any information you may be able to provide.

Yours sincerely

Mr F O Osikoya
Principal Occupational Therapist, Orthopaedic Hospital
Kano, Nigeria

Enc.

UNIVERSITY OF STIRLING STIRLING FK9 4LA SCOTLAND | Telephone: STIRLING (0786) 73171

Telex: 711759 STUNY G

APPENDIX 6BTHE LETTER WHICH ACCOMPANIED THE QUESTIONNAIRE TO THE
OCCUPATIONAL THERAPY NATIONAL ASSOCIATIONS IN VARIOUS COUNTRIES

Dear Sir

I am writing to you to request your assistance on the matter of the professional education of occupational therapists. I am currently on leave from my post in the occupational therapy service in Nigeria, doing post-graduate studies in preparation for my return to Nigeria when I shall assume responsibility for the provision of the professional education of occupational therapists throughout that country.

As part of my present studies, I wish to obtain the fullest possible information on the professional education of occupational therapists in various countries. As a first step, I would be most grateful if you could let me have any publications of your own association, and if possible any further information which you could supply personally in writing, about the position of your association on such matters as student admission, training institutions, curriculum and accreditation.

In order to indicate more fully the matters on which I am seeking your assistance, I have attached to this letter a more extended outline.

I look forward to hearing from you and I shall be grateful for any information you may be able to provide.

Yours sincerely

Mr F.O. Osikoya
Principal Occupational Therapist, Orthopaedic Hospital,
Kano, Nigeria

APPENDIX 6C

THE QUESTIONNAIRE WHICH WAS SENT TO THE WORLD FEDERATION OF OCCUPATIONAL THERAPISTS AND THE OCCUPATIONAL THERAPY NATIONAL ASSOCIATIONS

(1) STUDENT ADMISSION

Entrance characteristics which a student should possess to be admitted into occupational therapy training programme e.g. academic qualifications, personal characteristics age, work experience.

(2) TRAINING INSTITUTION

(a) Type of institution and location appropriate for training occupational therapists e.g. hospital based, university.

(b) Any requirement for the training institution to be affiliated to other institutions e.g. university medical school.

(3) CURRICULUM

The requirements or views of the professional association in relation to length of programme; programme aims, objectives and contents; amount and distribution of theoretical contents and of technical and clinical practice; methods of training; and assessment procedures

(4) FACULTY

Any requirements or views of the professional association in relation to the qualifications, experience or other characteristics of staff involved in the training programme

(5) FACILITIES

Any requirements or views of the professional association on types, standards, and extent of facilities needed to support the training programme

(6) ACCREDITATION

The roles of the professional association, if any, in the accreditation/registration of the members of the profession.

APPENDIX 6D

THE LETTER WHICH ACCOMPANIED THE QUESTIONNAIRE TO ALL THE OCCUPATIONAL THERAPY TRAINING SCHOOLS IN THE U.K.

Department of Education

Professor J. H. Duthie, (Head of Department)

Professor A. T. Morrison

UNIVERSITY OF STIRLING STIRLING FK9 4LA SCOTLAND | Telephone: STIRLING (0786) 73171
Telex: 777759 STUNIV.G

Dear Sir,

I am writing to you to request your assistance on the matter of the professional education of occupational therapists. I am currently on leave from my post in the occupational therapy service in Nigeria, doing post-graduate studies in preparation for my return to Nigeria when I shall assume responsibility for the provision of the professional education of occupational therapists throughout that country.

As part of my present studies, I wish to obtain the fullest possible information on the professional education of occupational therapists in the various occupational therapy training schools in the United Kingdom. As a first step, I would be most grateful if you could let me have any available written plans of your own training programme and, if appropriate, any supplementary information which you could supply personally in writing about the policy and practice of your own training school on such matters as student admission and enrolment, curriculum, staffing, teaching facilities and student assessment.

In order to indicate more fully the matters on which I am seeking your assistance, I have attached to this letter an outline of my interests.

I look forward to hearing from you and for any information you may be able to provide.

Yours sincerely

Mr F.O. Osikoya
Principal Occupational Therapist, Orthopaedic Hospital, Kano, Nigeri

APPENDIX 6E

THE QUESTIONNAIRE SENT TO ALL THE OCCUPATIONAL THERAPY TRAINING SCHOOLS IN THE U.K.

(1) STUDENT ADMISSION AND ENROLMENT.

- (a) Entrance characteristics which a student should possess to be admitted into the occupational therapy training programme e.g. academic qualifications, personal characteristics, age, work experience.
- (b) Number of students admitted per year, factors which determine that number, and selection procedures.

(2) CURRICULUM

Characteristics of the curriculum plan:

- (a) Processes by which the curriculum plan was developed and by which it is monitored.
- (b) Objectives of the curriculum.
- (c) The curriculum contents; the sequence and interrelation of different components; time allocation to theoretical, technical and clinical components.
- (d) Main types of teaching methods.
- (e) Student assessment procedures.

(3) STAFFING

- (a) Qualifications, experience and number of staff involved in the training programme.
- (b) Method of staffing; proportion of staff engaged in the programme who are, for example, full-time on this programme, staff from other departments of your institution and visiting specialists.

(4) FACILITIES

Nature and extent of facilities provided for the training programme, e.g. provision for individualised learning, specialist occupational therapy equipment, clinical placements, audio-visual facilities.

APPENDIX 7

THE CORRESPONDENCE WITH THE TWO OCCUPATIONAL THERAPY TRAINING PROGRAMMES SELECTED FOR THE CASE STUDIES IN SCOTLAND

Professor J. H. Duthie, (Head of Department)

UNIVERSITY OF STIRLING STIRLING FK9 4LA SCOTLAND | Telephone: STIRLING (0786) 73171
Telex: 171159 STUNIV G

Miss M E C Loggie, T.Dip., COT., SROT
Head of Department
Department of Occupational Therapy
Queen Margaret College
Clerwood Terrace
EDINBURGH EH12 8TS

16 October 1985

Dear Miss Loggie

You may recall that I wrote to you earlier this year to request some information on the professional education of occupational therapists. In that earlier correspondence, I explained that my interest arose from the fact that I have been sent to Scotland by the Nigerian government to undertake studies of policies and practices in the professional education of occupational therapists, with the expectation that on my return to Nigeria in 1986, I will become responsible for the establishment of a new school of occupational therapy.

I am now at a stage in my studies at which it would be most valuable to me if I could work more closely for a short period with one or two schools of occupational therapy in Scotland, doing so in a way which would allow me to obtain an understanding of the particular work of each school. Consequently, I should be most grateful if you would agree to my visiting you briefly in the near future in order to discuss the possibility of allowing me to work with your school and to discuss the kinds of things it would be helpful for me to do.

I should be grateful if you would let me know a time when it would be convenient to you for us to meet.

Yours sincerely

F O Osikoya
Post Graduate Student
Department of Education
University of Stirling
STIRLING FK9 4LA

UNIVERSITY OF STIRLING STIRLING FK9 4LA SCOTLAND | Telephone: STIRLING (0786) 73171
Telex: 777759 STUNIV G

Miss M E C Loggie, T.Dip., COT., SROT
Head of Department
Department of Occupational Therapy
Queen Margaret College
Clerwood Terrace
EDINBURGH EH12 8T5

16 October 1985

Dear Miss Loggie

Mr Francis Osikoya

I am enclosing this letter with the letter to you from Mr Osikoya himself in order to give my formal endorsement to the request he is making for an appointment with you to discuss the possibility of your supporting the work he is currently engaged in.

I, together with Mr D McIntyre who is his other supervisor, have worked closely with Mr Osikoya over the past year. He is an able and personable young man who will return to Nigeria to assume responsibility for the first school of Occupational Therapy in that country. Mr McIntyre and I believe that he can learn much of great value to his future work from talking to heads and members of schools/departments of occupational therapy in Scotland and we hope, therefore, that you will be willing both to have an initial meeting with him to discuss what he would hope to do and to provide him with appropriate facilities.

Yours sincerely

Professor Arnold Morrison

UNIVERSITY OF STIRLING STIRLING FK9 4LA SCOTLAND | Telephone: STIRLING (0786) 73171
Telex: 777759 STUNIV G

Mrs B Hudson, T.Dip.,COT; SROT
Principal
Glasgow School of Occupational Therapy
29 Sherbrooke Avenue
GLASGOW G41 4ER

16 October 1985

Dear Mrs Hudson

You may recall that I wrote to you earlier this year to request some information on the professional education of occupational therapists. In that earlier correspondence, I explained that my interest arose from the fact that I have been sent to Scotland by the Nigerian government to undertake studies of policies and practices in the professional education of occupational therapists, with the expectation that on my return to Nigeria in 1986, I will become responsible for the establishment of a new school of occupational therapy.

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Yours sincerely

F O Osikoya
Post Graduate Student
Department of Education
University of Stirling
STIRLING FK9 4LA

UNIVERSITY OF STIRLING STIRLING FK9 4LA SCOTLAND | Telephone: STIRLING (0786) 73171
Telex: 777759 STUNIV G

Mrs B Hudson, T.Dip.,COT; SROT
Principal
Glasgow School of Occupational Therapy
29 Sherbrooke Avenue
GLASGOW G41 4ER

16 October 1985

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Yours sincerely

Professor Arnold Morrison

Queen Margaret College

EDINBURGH

Clerwood Terrace · Edinburgh · EH12 8TS

Telephone : 031-339 8111 Principal: Donald Leach, BSc, FIMA, CPhys, MInstP, MBC



 DEPARTMENT OF OCCUPATIONAL THERAPY Head of Department: Miss M.E.C. Loggie, TDipCOT, SROT

MECL/MM

31 October 1985.

Mr F.O. Osikoya,
 Post Graduate Student,
 Department of Education,
 University of Stirling,
 Stirling, FK9 4LA

Dear Mr Osikoya,

Thank you for your letter, and the enclosed letter from Professor Morrison, expressing your wish to come and work more closely with us for a short period; I have spoken to the Principal of the College, Mr Leach, and to the staff in my department all of whom would be happy to welcome you to Queen Margaret College.

Perhaps you could arrange to come and see me on the afternoon of Thursday 7 November or some time on Friday 8th, so that we can discuss a programme which would be interesting and helpful for you.

Will you please telephone me, or my secretary Ext.202), to confirm a time.

Yours sincerely,

Head of Department.

GREATER GLASGOW HEALTH BOARD

GLASGOW SCHOOL OF OCCUPATIONAL THERAPY

Principal
Mrs. B. R. Hudson, T.Dip C.O.T., S.R.O.T

29 SHERBROOKE AVENUE
GLASGOW G41 4ER
TELEPHONE: 041-427 0032/3

BPR/304

23rd October 1985.

Mr. F.O. Osikoya,
Post Graduate Student,
Department of Education,
University of Stirling,
Stirling FK9 4LA.

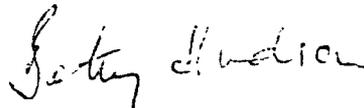
Dear Mr. Osikoya,

Thank you for your letter of 16th October.

I will be happy to help you in your studies.

Perhaps you would contact my secretary,
Mrs. Macfie, to arrange a date and time suitable
to go back to discuss the matter further.

Yours sincerely,



Principal

UNIVERSITY OF STIRLING STIRLING FK9 4LA SCOTLAND | Telephone: STIRLING (0786) 73171
Telex: 777759 STUNIV G

Mrs B Hudson, T.Dip.,COT., SROT.
Principal
Glasgow School of Occupational Therapy
29 Sherbrooke Avenue
GLASGOW G41 4ER

12 December 1985

Dear Mrs Hudson

I write on behalf of Professor Arnold Morrison and myself to express our warmest thanks for the generosity with which you have helped our research student, Francis Osikoya. We recognize the considerable demands which his studies have made on you, your staff and your students, and because of that we especially appreciate the way he was made to feel welcome at Glasgow School of Occupational Therapy and the readiness with which everyone shared their experience and insights with him.

It is already clear from our discussions with Francis that he has gathered a great deal of valuable information at Glasgow School of Occupational Therapy, and that this will have a considerable impact on his planning for a school of occupational therapy in Nigeria. His first task, which will take him some weeks, must be to analyse the information he has acquired and to write an account of what he has learned from you, your staff, and your students. I hope you will find time to read his account and that you will find it thoughtful, interesting and accurate.

In the meantime, please accept our gratitude for all your help.

Yours sincerely

Donald McIntyre
Reader in Education

UNIVERSITY OF STIRLING STIRLING FK9 4LA SCOTLAND | Telephone: STIRLING (0786) 73171
Telex: 77759 STIRLING

Miss M E Loggie, T.Dip., COT., SROT.
Head of Department
Department of Occupational Therapy
Queen Margaret College
Clerwood Terrace
EDINBURGH EH12 8TS

12 December 1985

Dear Miss Loggie

I write on behalf of Professor Arnold Morrison and myself to express our warmest thanks for the generosity with which you have helped our research student, Francis Osikoya. We recognize the considerable demands which his studies have made on you, your staff and your students, and because of that we especially appreciate the way he was made to feel welcome at Glasgow School of Occupational Therapy and the readiness with which everyone shared their experience and insights with him.

It is already clear from our discussions with Francis that he has gathered a great deal of valuable information at Glasgow School of Occupational Therapy, and that this will have a considerable impact on his planning for a school of occupational therapy in Nigeria. His first task, which will take him some weeks, must be to analyse the information he has acquired and to write an account of what he has learned from you, your staff, and your students. I hope you will find time to read his account and that you will find it thoughtful, interesting and accurate.

In the meantime, please accept our gratitude for all your help.

Yours sincerely

Donald McIntyre
Reader in Education

APPENDIX 10

THE COURSE SYLLABUS FOR THE NIGERIAN PROGRAMME

BIOLOGICAL SCIENCES

The study of biological sciences runs concurrently with studies in behavioural sciences, practical skills, the theory, principles and practice of occupational therapy. The study has been divided into two units (1) Anatomy and Physiology, (2) Kinesiology.

COURSE TITLE: Anatomy and Physiology

POSITION IN PROGRAMME: Year 1, Term 1, 2, 3

TIME ALLOCATION: 32 weeks x 4 hours = 128 hours

AIMS

1. To enable students to gain knowledge and understanding of the structure, function and development of the human body and its various systems.
2. To prepare and provide the students with a knowledge base for studying and understanding the human body when it deviates from normal.
3. To enable the students to apply the knowledge gained to the study and practice of occupational therapy.

OBJECTIVES

Upon completion of the course, the student will be able to:

1. Identify the structures of the various organs and systems of the human body.
2. Describe the functions of the various organs and systems of the human body.
3. Discuss the interrelationships of various body organs and systems in total body functioning.

COURSE CONTENTS

Terminology, structure, function, development and inter-relationship of components of human organism: cells, tissues, organs and systems of the human body. The course will cover in general form the structure and function of:

Digestive system: diet, composition, digestive tract, digestion, liver, pancreas.

Reproductive system: reproductive organs, normal development.

Excretory system: Kidney, mechanics of micturition.

Respiratory system: Lungs, trachea, regulation of respiration.

Endocrine system: Pituitary, thyroid, suprarenal, gonads and parathyroid glands. Hormonal control.

The areas of the course to be given greater emphasis because of their relevance and application to occupational therapy are the study of structure and function of the:

Nervous system: central nervous system, cranial nerves, peripheral nervous system, autonomic nervous system.

Cardiovascular system: Components of blood, blood vessels, heart, blood circulation.

Musculo-skeletal system: Bones, joints, movements of upper and lower limbs, spine, trunk; muscles, ligaments, tendons, acting on joints of upper and lower limbs, spine and trunk. Blood and nerve supply.

TEACHINGMethods

Lectures 2 hours per week
Practicals 1 hour per week

Instructors

Specialists

Tutorials 1 hour per week

Occupational
Therapists

ASSESSMENT

1. Methods: Essay questions, assignments, multiple-choice short notes, practical.
2. Types:
 - a) Continuous assessment
 - 1 test middle of each term
 - 1 test end of 1st and 2nd term
 - b) Final examination at end of course.

COURSE TITLE: Kinesiology

POSITION IN PROGRAMME: Year 1, Term 3

TIME ALLOCATION: 6 weeks x 4 hours = 24 hours

This is a short course concerned with the study of applied anatomy and physiology, muscular system in relation to muscle and joint movement, normal body movement and co-ordination of movement.

AIMS

The aims of the course are to provide the student with the understanding of physical function of the individual in relation to posture, mobility, movement and such adverse effects upon the individual's interaction with his environment.

OBJECTIVES

At the end of the course, the student will be able to:

1. Identify normal and abnormal body movements.
2. Describe causes of abnormal body movements.
3. Analyse body movement patterns, limitations and corrective measures.
4. Demonstrate competence in the use of equipment in testing muscle strength, joint range and patient handling.

COURSE CONTENTS

Muscle movements, actions and testing; joint motion, co-ordination, testing and measurement. Use of instruments for testing muscle strength and joint range. Postural analysis - lever systems, energy, force, body mechanics, normal and abnormal body movements, especially in relation to the movements of the upper and lower limbs, spine and trunk. Body co-ordination and balance. Effects of vestibular, visual impairments and gravity on body movements. Patient handling - transfer techniques, principles of lifting, carrying, pushing and pulling.

TEACHINGMethods

Lectures 2 hours per week
 Practical 1 hour per week

Instructors

Specialists

Tutorials 1 hour per week

Occupational
TherapistsASSESSMENT

1. Methods: Essay questions, assignments, multiple-choice, short notes.
2. Types:
 - a) Continuous assessment
 - 1 test middle of course
 - 1 assignment
 - b) Final examination at end of course.

BEHAVIOURAL SCIENCES

The study of behavioural sciences runs concurrently with studies in biological sciences, practical skills, the theory, principles and practice of occupational therapy. The study of behavioural sciences has been divided into two units: (1) Psychology, (2) Medical Sociology.

COURSE TITLE: Psychology

POSITION IN PROGRAMME: Year 1, Term 1, 2.

TIME ALLOCATION: 26 weeks x 4 hours = 104 hours

AIMS

1. To introduce students to a general understanding of human behaviour.
2. To introduce students to a variety of communication skills.
3. To lay in the students the foundation for studying the medical sciences later in the programme and their relevance and application to occupational therapy.

OBJECTIVES

Upon completion of the course, the student will be able to:

1. Identify psychological factors responsible for human behaviours and actions.
2. Demonstrate knowledge and ability in using various communication skills.
3. Apply the knowledge gained in the course to the practice of occupational therapy.

COURSE CONTENTS

Selected topics in psychology concerned with normal human functioning and essential for practising occupational therapy are chosen. The relevant aspects of study include human development from childhood through to old age, personality, learning, memory, perception, intelligence, motivation, emotion, interpersonal behaviour and communication skills.

TEACHINGMethods

Lectures
Practicals

2 hours per week
1 hour per week

Instructors

Specialists

Tutorials

1 hour per week

Occupational
TherapistsASSESSMENT

1. Methods: Essay questions, short notes, assignments

2. Types: a) Continuous assessment

1 test middle of each term
1 test end of 1st term
2 assignments

b) End of course final examination

COURSE TITLE: Medical Sociology
POSITION IN PROGRAMME: Year 1, Term 3
TIME ALLOCATION: 12 weeks x 4 hours = 48 hours

AIMS

1. To introduce students to the sociology of health and illness, and the influence of health and illness upon human interaction with the environment.
2. To familiarise students with characteristics of Nigerian society and patterns of social interaction introducing them to the type of society they will be dealing with in terms of the health-illness situation.
3. To lay in the students the foundations for studying the medical sciences later in the programme and their relevance and application to occupational therapy.

OBJECTIVES

Upon completion of the course, the student will be able to:

1. Identify sociological factors responsible for health-illness behaviour, with particular reference to Nigerian society.
2. Use the knowledge gained in understanding and learning medical sciences later in the programme.
3. Relate the information and knowledge gained to the practise of occupational therapy.

COURSE CONTENTS

Selected topics as they relate to Nigeria and relevant to the practice of occupational therapy are covered e.g. analysis of the Nigerian society in terms of social structure, socialization, human groups, roles. Selected social institutions e.g. family, religion; influence of illness upon human interaction with the environment; stress, poverty, disability, employment will be examined in the health-illness continuum.

TEACHINGMethods

Lectures
Practicals

2 hours per week
1 hour per week

Tutorials

1 hour per week

Instructors

Specialists

Occupational
Therapists

ASSESSMENT

1. Methods: Essay questions, short notes, assignments.
2. Types:
 - a) Continuous assessment
 - 1 test middle of term
 - 1 assignment
 - b) End of course final examination.

MEDICAL SCIENCES

The medical sciences concern the study of conditions which affect the health of individuals and their ability to lead full, purposeful and productive lives. The course which runs concurrently with the study of practical skills, the theory, principles and practice of occupational therapy, has been divided into two units: (1) Medicine and Surgery, (2) Psychiatry.

COURSE TITLE: Medicine and Surgery

POSITION IN PROGRAMME: Year 2, Term 1, 2

TIME ALLOCATION: 28 weeks x 5 hours = 140 hours

AIMS

1. To introduce the students to the nature of diseases and injuries and their effect upon the structure and function of the human body.
2. To give students sufficient knowledge of specific relevant medical, surgical and orthopaedic conditions which they may, as occupational therapists, be required to treat.
3. To identify functional problems which can arise from these conditions and their management by the inter-disciplinary health team.
4. To provide a knowledge base for the occupational therapy courses and clinical experience.

OBJECTIVES

Upon completion of this unit, students should be able to demonstrate:

1. Knowledge of medical, surgical and orthopaedic conditions treated by occupational therapists, as they apply to patients of different age groups.
2. Awareness of the relevance of the information gained and the use of such information and knowledge in planning occupational therapy programmes as they apply to patients of different age groups.

COURSE CONTENTS

The unit will include the study of aetiology, pathology, symptoms, treatment, preventative, rehabilitative and prognosis of general medical conditions affecting the respiratory and endocrine systems. To be studied with greater emphasis are diseases affecting the locomotor system e.g. cerebral palsy, muscular dystrophy; the nervous system, e.g. head injuries, multiple sclerosis, Parkinsonism, cardiovascular systems, e.g. strokes; rheumatic diseases e.g. arthritis.

In surgery, the unit will focus on aetiology, pathology, symptoms, treatment, preventative, rehabilitative and prognosis of acquired and congenital disorders with greater emphasis on orthopaedic and traumatic conditions e.g. fractures, amputations, nerve and tissue injuries, and bone diseases.

TEACHINGMethods

Lectures	3 hours per week
Practicals	1 hour per week
Tutorials	1 hour per week

Instructors

Specialists

Occupational
TherapistASSESSMENTS

1. Methods: Essay questions, short notes, multiple choice assignments.
2. Types :
 - a) Continuous assessment
 - 1 test middle of each term
 - 1 test end of 1st term
 - 2 assignments
 - b) End of course final examination

COURSE TITLE: Psychiatry

POSITION IN PROGRAMME: Year 2, Term 1, 2

TIME ALLOCATION: 28 weeks x 5 hours = 140 hours

AIMS

1. To introduce the students to the nature of psychological problems and their effects upon the structure and function of the human mind.
2. To give students sufficient knowledge of psychiatric conditions which they may as occupational therapists be required to treat.
3. To identify functional problems which can arise from these conditions and their management by the interdisciplinary health team.
4. To provide a knowledge base for the occupational therapy courses and clinical experience.

OBJECTIVES

Upon completion of this unit, students should be able to demonstrate:

1. Knowledge and understanding of psychiatric conditions treated by occupational therapists as they apply to patients of different age groups.
2. Awareness of the relevance of the information gained and the use of such information and knowledge in planning occupational therapy programmes as they apply to patients of different age groups.

COURSE CONTENTS

The unit, which covers psychological problems which occur in childhood, adolescence, adulthood, middle age and old age, covers the study of aetiology, pathology, symptoms, treatment, presentation, rehabilitation and prognosis of conditions such as psychoneurosis, e.g. anxiety states, obsession neurosis, affective psychosis, e.g. schizophrenia, depression, organic psychosis e.g. dementia, cerebral lesions; personality disorders e.g. psychopathic personality; alcoholism and drug dependence and mental handicap.

TEACHINGMethods

Lectures
Practicals

3 hours per week
1 hour per week

Instructors

Specialists

Tutorials

1 hour per week

Occupational
TherapistsASSESSMENTS:1. Methods:

Essay questions, short notes, multiple
choice, assignments.

2. Types:

a) Continuous assessment

1 test middle of each term
1 test end of 1st term
2 assignments

b) End of course final examination

COURSE TITLE: Clinical Practice

POSITION IN PROGRAMME: Year 1, Term 1 (last two weeks)
Term 2 (first two weeks)

TIME ALLOCATION: 4 weeks x 40 hours = 160 hours

The clinical practice which is for a short period and is for observation purposes, is divided into two weeks each in two major occupational therapy service areas:

1. Occupational therapy with patients suffering from psychiatric disorders.
2. Occupational therapy with patients suffering from physical disorders.

AIMS

1. To provide students with insight into the different aspects of the work of occupational therapists and the range of patients occupational therapists deal with.
2. To provide students with an understanding of the roles of occupational therapists in an inter-disciplinary health care set-up.
3. To expose students to the practise of the profession early in the course.
4. To foster students' enthusiasm for the profession, confirm their interest in the profession and reinforce their career choice.
5. To show the students the operation of an occupational therapy department.

OBJECTIVES

Upon completion of the unit, the student will be able to:

1. Describe the work of an occupational therapist.
2. How occupational therapists carry out their functions.
3. The settings in which occupational therapists work.

TEACHING

1. Methods: Clinical demonstration, discussion, observing occupational therapists at work, attendance at case conferences.
2. Instructors: Clinical Supervisors.

ASSESSMENT METHODS

There will be no formal assessment in this unit but students will be asked to write a report of their observation.

<u>COURSE TITLE:</u>	Clinical Practice 1 & 2
<u>POSITION IN PROGRAMME:</u>	Year 2, Term 3
<u>TIME ALLOCATION:</u>	Year 3, Term 1, 2
<u>TIME ALLOCATION:</u>	40 weeks x 40 hours = 1600 hours

The two major clinical practices slotted for second and third year are a progression through 40 weeks, divided into two units of 20 weeks each, to give students supervised clinical experience in two major occupational therapy service areas.

1. Occupational therapy with patients suffering from psychiatric disorders.
2. Occupational therapy with patients suffering from physical disorders.

The clinical experience in each area will be done in rotation.

AIMS

1. To give students the opportunity to apply and practise knowledge and skills gained in school and the acquisition of new skills.
2. To provide students with experience in problem diagnosis and solving and how to handle patients.
3. To develop in the students professional skills, attitudes, roles and confidence in preparation for practice as occupational therapists.
4. To increase students' knowledge and understanding of the work of other health professions.
5. To provide the students with the opportunity to become involved in the practise, management and administrative skills involved in the delivery of an occupational therapy service.

OBJECTIVES

Upon completion of the units, the students will be able to:

1. Describe patients' referral system.
2. Select an appropriate occupational therapy assessment method.

3. Formulate treatment goals and programmes that are realistic and appropriate to the patients' needs.
4. Demonstrate ability in the appropriate selection and use of media, techniques and resources.
5. Implement treatment plans.
6. Monitor and evaluate patients' progress.
7. Make appropriate decisions as to discontinuation of treatment and plans for follow-up.
8. Communicate findings and decisions to the rest of the treatment team associated with the patient's care.
9. Understand and use resources available to patients in the community.
10. Understand and practise the profession's roles and ethics.
11. Apply management principles in the running of an occupational therapy department.
12. Understand the roles of other health care professions.

COURSE CONTENTS

Each student will be assigned to work in an occupational therapy department under supervision of a qualified occupational therapist. Students will take part in all aspects of occupational therapy professional practice. A clinical practice log book will be maintained by each student, showing weekly hours completed, type of patients seen and treated as well as other activities in the placement and signed by the clinical supervisor.

TEACHING

1. Methods: Practical sessions, tutorials, discussion, clinical demonstration, lectures, seminars, case presentation, attendance on ward rounds, observing occupational therapists at work.
2. Instructors: Clinical Supervisors

ASSESSMENTS

- a) Schedule: Middle and end of each placement.
- b) Types: Oral viva, completion of specific tasks, projects, reference folio.
- c) Methods: Written reports from Clinical Supervisors.

PRACTICAL SKILLS

Practical skills are therapeutic activities and media used in occupational therapy. The course runs concurrently with biological, behavioural, medical sciences and the theory, principles and practise of occupational therapy.

The study of practical skills is divided into four major areas:

1. Work-related skills
2. Social skills
3. Personal and self-care skills
4. Recreational and leisure skills

COURSE TITLE: Practical Skills 1, 2, 3, 4

POSITION IN PROGRAMME Year 1, Term 1, 2, 3
Year 2, Term 1, 2

TIME ALLOCATION: 66 weeks x 6 hours = 396 hours

AIMS (combined)

1. To expose students to knowledge and understanding of the various therapeutic activities, techniques and skills used in the occupational therapy setting.
2. To develop in the students the knowledge, skills, competence and confidence in practising, selecting, analysing and application of these skills for their therapeutic purposes.
3. To provide the students with the skill and techniques of teaching, and relating and communicating with patients.
4. To develop in the students the practical experiences with which the theoretical principles concerning the use of activities can be integrated during the course.
5. To expose students to the skills of using, choosing, handling and care of tools, materials, and equipment used in a variety of practical skills and occupational therapy set-ups.

OBJECTIVES (combined)

Upon completion of the course, the student will be able to:

1. Demonstrate knowledge of a variety of practical skills and their therapeutic application in occupational therapy.
2. Discuss the rationale for the selection and the application of such methods for a given patient.
3. Analyse these therapeutic activities for their therapeutic potential.
4. Adapt and modify various practical skills to meet the needs of different patients.
5. Demonstrate competence and understanding in the safe usage and handling of a variety of tools, materials and equipment used in an occupational therapy setting.
6. Demonstrate ability in interpersonal and communication skills.

COURSE CONTENTS

Study of therapeutic activities, techniques and skills which provide exercise potential and rehabilitating patients who have suffered illness or disability back into the working situation. This involves the study of methods of work and different work situations, principles of work: work assessment, sampling, design, analysis, adaptation, energy conservation, safety factors. Physiological and psychological aspects of work.

Job skills: interview, presentation, attendance, punctuality, interaction with peers and relating with authority and employer. Light and heavy manual activities such as woodwork, metalwork, leatherwork, gardening, printing, weaving, clerical work, job simulation; activities with exercise potential, such as use of special equipment, e.g. rehabilitation machine, lathe, arm mobilizer, ankle rotator.

Social skills: study of selected activities as media for facilitating interpersonal, social and communication skills e.g. use of drama, group discussion, dancing, music, games to promote communication and social confidence; use of art as projective technique.

Personal and self-care skills: study of selected methods of coping with disability where personal, self-care and domestic independence is a problem, e.g. reading, dressing, bathing, toileting, laundry, kitchen work, cooking, menu planning; household management: budgetting, house-cleaning; use of public transport, shopping; use and care of aids and appliances; principles of design of aids, appliances,

equipment, environmental assessment, safety in the home and at work, home re-adaptation, elimination of fatigue and energy conservation. Splintmaking.

Recreational and Leisure skills: study of selected activities and methods in the pursuit of leisure: sports, art - painting and drawing; games, music, exercise, relaxation, pottery, etc.

TEACHING

Methods

Instructors

Lectures: 2 hours per week

Occupational
Therapists

Practicals, individual and group work: 4 hours per week

ASSESSMENT

1. Types: Assignments, completion of folio and assigned projects and oral, practical examination.

2. Method: Completion of folio on each activity.
Completion of assigned project on each activity.
2 assignments on each activity.

Final oral practical examination at the end of each activity.

THEORIES, PRINCIPLES AND PRACTICE OF OCCUPATIONAL THERAPY

This particular course has been divided into 3 major study areas: Occupational Therapy Studies 1, 2 and 3. The first part introduces students to the profession, its principles and models of practice. The second part deals with the application of occupational therapy to different health conditions and problems. The third part concerns the study of the administration of an occupational therapy department and assigned student independent study.

COURSE TITLE: Occupational Therapy Studies 1

POSITION IN PROGRAMME: Year 1, Term 1, 2, 3

TIME ALLOCATION: 38 weeks x 6 hours = 228 hours

AIMS

1. To introduce students to occupational therapy as a health profession, its roles and those of other health professions in a multi-disciplinary health team.
2. To introduce the students to the principles and techniques of occupational therapy and the opportunity for the acquisition of basic skills and techniques used in occupational therapy.
3. To introduce students to theories as a philosophical basis for occupational therapy and the influence different theoretical approaches have on occupational therapy practice.
4. To prepare students for application of this knowledge and skills later in the course, and in clinical practice.

OBJECTIVES

Upon completion of the course, the student will be able to:

1. Discuss occupational therapy, its history, development and roles in health care; roles of other health professions.
2. Discuss the principles and techniques used in occupational therapy: data gathering, assessment, organising and using information, evaluation and communication as they are appropriate to occupational therapy.
3. Discuss and outline the theories and treatment approaches used in occupational therapy.

COURSE CONTENTS

1. Introduction to Occupational Therapy as a Health Profession

What occupational therapy is, its history, development, goals, functions, philosophy, scope, treatment setting, types of patients they deal with.

Roles of occupational therapy in a multi-disciplinary health care team. Roles of other health care professions in the team: doctors, nurses, physiotherapists, orthotists, social worker, radiographers, medical records officers, psychologists.

Uses of activities in occupational therapy: importance of knowledge of behavioural, bio-medical knowledge, practical skills and clinical practice to this course in the programme.

2. Principles of Occupational Therapy

Acquiring information about patients: data gathering, referral systems, medical records.

Assessments: As a tool in data gathering, investigative procedures, preliminary to planning treatment, determining treatment progress and final decision.

Assessment methods: practical methods of identifying problems in patients, e.g. interviewing, questionnaire observation, measurements, examinations, timing, use of standardized and non-standardized tests, experimental situations. Selection of appropriate methods.

Treatment Planning: organising and using information, setting treatment aims, goals and plans, selecting an appropriate treatment medium.

Communication: documentation, reporting and recording information - written and verbal, patients' records, interpretation of data.

3. Theories of Occupational Therapy

Different approaches used in occupational therapy, criteria and indications for their use: Biomechanical, Developmental, Behavioural, Rehabilitative, Psycho-analytical, Holistic and Humanistic approaches.

ASSESSMENT

1. Methods: Essay questions, assignments, short notes.
2. Types:
 - a) Continuous assessment
 - 1 test middle of each term
 - 1 test end of 1st and 2nd term
 - 2 assignments
 - b) End of course final examination.

COURSE TITLE: Occupational Therapy Studies 2

POSITION IN PROGRAMME: Year 2, Term 1, 2

TIME ALLOCATION: 28 weeks x 6 hours = 168 hours

The course concerns the application of theoretical and practical knowledge, the principles and theories of occupational therapy to treatment, prevention and rehabilitation of patients suffering from physical, surgical and psychiatric conditions, currently taught in the course.

AIMS

1. To assist the student to an understanding of the relevance of all subjects taught in the course and their importance to the practise of occupational therapy.
2. To introduce the students to the application of occupational therapy to the management of patients suffering from selected medical, physical, surgical and psychiatric conditions.
3. To draw together all the knowledge gained in the course.
4. To prepare students for clinical practice.

OBJECTIVES

Upon completion of the course, the student will be able to:

1. Demonstrate the importance of the knowledge taught in the course.
2. Apply the principles and techniques used in occupational therapy to selected health conditions.
3. Demonstrate the applicaton of specific treatment approaches used in occupational therapy to specific health conditions.

COURSE CONTENTS

Practise of occupational therapy: Application of all theoretical and practical knowledge and skills, the principles, theories of occupational therapy to the treatment, prevention and rehabilitation of selected general, medical, physical, surgical and psychiatric conditions.

TEACHINGMethods

Lecture 1 hour per week
Tutorials, practicals, case studies,
simulations, group work = 5 hours per week

Instructors

Occupational
Therapists

ASSESSMENTS

Methods: Essay questions, short notes, assignments,
practicals.

Type:

- a) Continuous assessments
 - 1 test middle of 1st and 2nd term
 - 1 test end of 1st term
 - 2 assignments
- b) End of course final examination
(written and oral)

The Occupational Therapy Studies 3 has been divided into two areas: 1) Management in Occupational Therapy, 2) Independent Study.

COURSE TITLE: Occupational Therapy Studies 3
(Management in Occupational Therapy)

POSITION IN PROGRAMME: Year 2, Term 2

TIME ALLOCATION: 14 weeks x 1 hour = 14 hours

AIMS

1. To introduce students to the management techniques required in the running of an occupational therapy department.
2. To introduce students to communication skills required in the delivery of a health care service.
3. To introduce students to legal considerations in the practice of occupational therapy.

OBJECTIVES

Upon completion of the course, the student will be able to:

1. Demonstrate proficiency in both written and oral communication skills relevant to the delivery of a health care service.
2. Outline principles and methods of organization relevant to occupational therapy.
3. Discuss financial control, acquisition of resources as they apply to the occupational therapy setting.
4. Discuss legal issues as they affect or relate to the practice of occupational therapy in Nigeria.

COURSE CONTENTS

Introduction to management. How to manage and organize an occupational therapy department, management of personnel.

Communication in professional administration: verbal, written reporting, letter writing, lines of authority in the hospitals and occupational therapy department.

Departmental administration: systems for patients and staff record keeping, confidentiality of information; control of equipment, materials, tools, storage, purchase, book-keeping, budgetting, safety.

Staff supervision: evaluation, writing confidential reports, selection, interview.

Health laws and legal issues in Nigeria.

TEACHINGMethod

Lecture

1 hour per week

InstructorsOccupational
TherapistASSESSMENT

1. Method: Essay questions, short notes
2. Type:
 - a) Continuous assessment
1 test middle of course
 - b) End of course final examination.

COURSE TITLE: Occupational Therapy Studies 3
(Independent Study)

POSITION/TIME ALLOCATION IN PROGRAMME

Each student is required, as part of the programme, to complete an independent project study in an area relevant to occupational therapy. Students are introduced to the requirements and purpose of the study at the beginning of the second term of second year, before starting the first major clinical practice.

The study is aimed to show in each student, proof of further integration and personal and professional development in the course.

TEACHING METHOD

Each student is assigned to a member of faculty staff for supervision and guidance.

ASSESSMENT METHOD

The completed project will be marked 'pass' or 'fail'.

6.1 Introduction

Occupational therapy is practised worldwide, and the profession is regulated by the World Federation of Occupational Therapists, various national associations and the individual training schools. This chapter examines the documentation produced by these bodies and the implication of the findings for the possible development of a training programme in Nigeria.

The investigation conducted and reported in this chapter was designed to find out what is happening in occupational therapy training in other places and the views people hold on matters of professional education of occupational therapists. It was expected that the findings would be important in making suggestions for realistic planning in the Nigerian situation.

6.2 Procedure Employed

As already discussed in Chapter 5, the postal questionnaire technique was used. Questionnaires were sent to the World Federation of Occupational Therapists (WFOT), Occupation Therapy National Associations in different countries and Occupational Therapy Training Schools in the United Kingdom. As a first step, a letter was sent to the WFOT requesting lists of names and addresses of all

The philosophy underlying the course assessments practised by the schools was not clearly spelt out. For example, their determination of course grading, making up examinations, marking of students' papers, collating marks, interpretation of marks, course weighting and the consequences of assessments were not made explicit.

Staffing

Information collected on staffing was limited. Most of the schools simply mentioned that their training was staffed by "fully qualified occupational therapists", "experienced occupational therapists", "psychologists", "surgeons", "physicians", "lectures are given by lecturers and medical consultants". However, as shown in Table 6.9, the number and type of staff in three training schools varied from school to school. In these schools all the occupational therapy lecturers are qualified professionally trained occupational therapists and have the qualifications of the Diploma of the College of Occupational Therapists (Dip.COT). In addition some have the Teacher's Diploma of the College of Occupational Therapists (T.Dip.COT), Certificate in Education, university degrees and post-graduate degrees.