2017 MScOT Program and Curriculum Document
Preamble

The Occupational Science and Occupational Therapy Program at the University of Toronto is guided by the Department’s Vision, Mission and Values, relevant evidence-based theories and practices, the accreditation standards of the Canadian Association of Occupational Therapy in Canada, the Minimum Standards for the Education of Occupational Therapists 2016 of the World Federation of Occupational Therapy, and the performance expectations for “competent” practice of occupational therapists as detailed in the Profile of Practice of Occupational Therapy in Canada (2012) and in the Essential Competencies of Practice for Occupational Therapists in Canada (2011). These materials provide the foundation for the program objectives and evaluation, curriculum planning, management and evaluation and the culture of educational scholarship in the Department.
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I. Vision, Mission and Values

Guiding Principle: The Department’s Vision, Mission and Values arise from the commitment to prepare leaders in occupational therapy and excellence and leadership in advancing the science of occupation and its enablement.

The Department’s Vision, Mission and Values were developed as part of a major strategic planning process in 2011. A review of these in 2017 led to the addition of Inter-professionalism as a value.

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II. Program Goals & Objectives

Guiding Principle: The MScOT program has a set of overarching goals and objectives that graduates are expected to achieve, that are responsive to the changing needs of society and that encourage the development of the breadth of competencies for occupational therapy practice in Canada.

In 2015, the Department developed their MScOT Program Logic Model (see Figure 1) as a depiction of the Program’s long-term and short-term objectives. The overall goal of the Program is “to create knowledge and prepare leaders in occupational science and occupational therapy to improve health and well-being locally and globally”. Short-term objectives are aligned with achieving competency in the seven roles identified in the Profile of Occupational Therapy in Canada (2012). The long-term objectives are that graduates are in roles that are contributing to the achievement of our mission.

MScOT Program Goal
To create knowledge and prepare leaders in occupational science and occupational therapy to improve health and well-being locally and globally.

MScOT Program Short-Term Objectives
At the end of the MScOT Program, graduates will demonstrate:
1. Ethical practice and high personal standards of behaviour (Professional Role)
2. The ability to manage time, prioritize, and support the management of effective and efficient practice (Practice Manager Role)
3. Expertise to advance occupation, occupational performance, and occupational engagement (Change Agent Role)
4. Use of evidence-based processes that focus on a client’s occupations as a medium for action and outcome (Expert in Enabling Occupation Role)
5. Expertise in oral, written, non-verbal and electronic communication (Communicator Role)
6. The ability to work effectively with key stakeholders to enable participation in occupations by using and promoting shared decision-making approaches (Collaborator Role)
7. Use of critique, reflection, and quality improvement in everyday practice and through lifelong learning (Scholarly Practitioner Role)

MScOT Program Long-Term Objectives
Within five years of graduation, graduates of the MScOT program will demonstrate: leadership in the supervision of support workers, through assumption of management roles, through involvement in the profession, and/or through entrepreneurship.
III. Professional Conceptual Framework

Guiding Principle: The MScOT program’s professional conceptual framework embodies notions of ‘health through occupation’ and scholarly-practitioner’ and is responsive to new and emerging theories in occupational science.

We are committed to advancing knowledge through excellence in research. As scholarly-practitioners, occupational therapists are expected to maintain a practice based on evidence, one aspect of which is current research. “Evidence-based occupational therapy is client-centred enablement of occupation that is based on client information, critical review of relevant research, expert consensus, and past experience” (CAOT, 1999/2009; Law & MacDermid, 2008). “Occupational therapists believe that evidence-based practice is a major element of what is now described as best practice”. (CAOT 1999/2009, para 2). Thus, we aim to graduate students with skills in contributing to programs of research and in the translation and utilization of research, leading to the advancement of knowledge supporting the profession.

Our professional conceptual framework provides the foundational philosophy and values statements of the Program and that inform our curriculum. Each of the values that are part of our professional conceptual framework is rooted in current and emerging occupational theory and practice and is encompassed in our values statements below.

1. Occupation: We believe in the value of occupation and its importance to health and well-being. This Value embraces the ideas that: a) humans are occupational beings; b) engagement in occupation is “a basic human need and right for all”; c) engagement in occupation is “required for survival, health and well-being”; d) occupational disruption can affect health and well-being and generate pathology; e) “occupation has therapeutic value”; f) “occupation brings meaning to life”; g) occupation allows us “to explore and learn from the environment, to master skills, to express our individuality, and to sustain life” (see CAOT, 2002; Christiansen & Townsend, 2010; Townsend & Polatajko, 2013, p. 20-21). Occupation-based practice holds that current and emerging occupational therapy practice must be focused on the enablement of occupational performance and engagement outcomes relative to health and well-being. Thus, occupation is viewed as not only a means of therapy but also an end/outcome of therapy that promotes health and well-being (Townsend & Polatajko, 2013).

We also believe in the importance of the environment as an influence on occupation and quality of life. Humans are “not decontextualized entities”; rather they “act on and interact with a myriad of environments, using occupation” (Townsend & Polatajko, 2013). Further, environments shape who we are as occupational beings and who we will become (Christiansen & Townsend, 2010) and contextual issues, such as physical and social environments, stigma, inequality, accessibility and alienation, influence occupational engagement and quality of life (Christiansen & Townsend, 2010; Townsend & Polatajko, 2013). Thus, understanding and addressing the environment’s role in occupational performance and engagement are crucial for effective occupational enablement and fostering quality of life.

2. Leadership: We value a variety of notions of leadership including the following portrayals:
   • a leader is anyone willing to help, anyone who sees something that needs to change and takes the first steps to influence that situation (Wheatley, 2008);
leadership is a process whereby an individual influences a group of individuals to achieve a common goal (Northouse, 2013); one can lead from any chair (Zander & Zander, 2000).

We believe that innovation and excellence in research, education and practice arises from a variety of forms of leadership.

3. **Interprofessional Collaboration:** *We are committed to collaborative relationships and partnerships with clients/caregivers and health/social care providers.* Collaboration is the KEY enablement skill in the Canadian Model of Client-Centred Engagement (CMCE) (Townsend & Polatajko, 2013). This value of collaboration has been part of our professional values for many years. “Congruent with enabling occupation, the production, retrieval, review, and evaluation of information is viewed as a joint responsibility of the client and therapist working in a collaborative relationship” (CAOT, 1997; CAOT, 1999, para. 4). Additionally, collaboration and communication with other health/social care providers enables a comprehensive client-centred approach.

4. **Diversity & Inclusion:** *We value cultural diversity and individual difference.* We view culture as a shared system of values, beliefs, ways of knowing or learned patterns of behaviours which are reflective of one’s intersecting identities as related to ethno-cultural background, gender expression and identity, sexual orientation, socioeconomic status, abilities, race, geographical location, or age. As such, “culture has an essential impact on occupational patterns and occupational choices that are indicative of cultural beliefs” (Townsend & Polatajko, 2013, p. 52). Culture influences our values or ways of engaging in the world. Importantly, “each occupation is uniquely experienced by the individual engaged in it” and “occupations are idiosyncratic” to each specific person (CAOT, 1997; Townsend & Polatajko, 2013, p. 22). The subjective and constructed nature of occupational meaning, purpose and engagement must be understood and appreciated through client-centred or individualized, culturally appropriate assessments and interventions.

We situate discussions of diversity within understandings of social inclusion and occupational justice concomitantly with oppression, privilege, discrimination, exclusion and injustice, all of which impact on occupational performance and engagement. Accordingly, an understanding of diversity must also consider how some forms of difference (i.e., identities or ways of doing, knowing and being) may be privileged (e.g., white, able-bodied, straight) and included while others (e.g., racialized, disabled, LGBT), may be excluded and oppressed (ACOTRO et al., 2014; Beagan, 2015). Awareness of the power inequities across various forms of diversity that play out in the dynamics of the practitioner-client interactions is essential to the value of equity and the maintenance of culturally humble, safe and inclusive approaches to maximizing occupational performance and engagement (CAOT, 2011; Hammel, 2013; Hook, et al., 20013).

5. **Client-centredness:** *We believe that people’s occupational repertoires are idiosyncratic and, as such, clients are the experts regarding their own life experiences and occupations. Therefore, clients must be active partners in occupational therapy process to realize the full potential of occupational engagement.* This value is a core component of client-centred enablement as it describes the type of enablement that is necessary to achieve a successful collaborative relationship and positive occupational outcomes. Client-centred enablement is based on the six enablement foundations: (a) choice, risk, and responsibility; (b) client participation; (c) visions of possibilities; (d) change; (e) justice; and (f) power sharing (Townsend, Polatajko, & Craik, 2013, p. 101).
6. **Professionalism:** We value professionalism and are committed to fostering its development throughout the MScOT Program. Occupational therapists are accountable, autonomous practitioners, and are solely accountable for their professional judgment (COTO, 2003, p.4). Students begin their learning about occupational therapists’ accountabilities on the first day of the MScOT program and continue this throughout the two years of academic and fieldwork education. The three Occupational Therapy Practice courses focus explicitly on students’ learning of specific professional accountabilities as well as their socialization into the professional culture of **accountability, integrity, life-long learning, transparency and critical inquiry.** Self, practice and program evaluation are taught as critical elements for the provision of occupational therapy best practices (Law, Baum, & Dunn, 2005).
IV: EDUCATIONAL Conceptual Framework

Our Educational Conceptual Framework (ECF; Appendix A), like our Professional Conceptual Framework (PCF), flows from our Vision, Mission, and Values & Beliefs statements. It includes our educational philosophy, guiding themes and principles and is foundational to the curriculum. As such, it provides guidance to faculty, and examples for faculty, to use when developing and implementing their courses and course assignments. It provides fundamental content regarding the philosophy, values and theories that inform approaches to the development and implementation of course content, instructional methods and evaluation methods. It also informs decision-making regarding curriculum development, renewal.

Integration of ECF and PCF

The close alignment and cohesion of the ECF and PCF stems from the fact that the Department’s Vision, Mission and Values are foundational to both. The goal of the Program relates to ensuring our graduates are competent to begin professional practice. The ECF supports the educational preparation of students in the MScOT Program. Accordingly, the MScOT Program’s goal, short-term outcome objectives and long-term outcome objectives are achieved, to a great extent (although not exclusively) through the complete curriculum.

Dissemination of ECF

The ECF was designed for use by all faculty and students. Since the development of our ECF (2012), we have been actively engaged in dissemination of the concepts and content to students, core faculty, status-only faculty, preceptors and other interested individuals. The full document is available in PDF form on the Department’s website http://ot.utoronto.ca/about/educational-conceptual-framework/ and all faculty are provided with a copy. An executive summary is included in the Departments’ Curriculum Policies and Guidelines Handbook (see Appendix B). A student-friendly executive summary version, written by past student representatives to the PCC, is included in the MScOT Graduate Student Handbook available to all students online (http://ot.utoronto.ca/current/student-handbook-important-notices/background/teaching-learning-methods/).

Active methods of dissemination include presentations at student orientations, emphasis on faculty linking their course content to learning theory in Atlas (the course and curriculum software management system used in the Department), presentation at the All Faculty Assembly, 2013, development of web-based interactive modules on the ECF available to all students, faculty and preceptors, and presentations at peer-reviewed scientific conferences including the Association for Medical Education in Europe (2015) and CAOT (2016).

Interprofessional Education and the ECF: The IPE learning activities are also developed using the learning theories presented in the ECF. Primary learning theories informing the IPE curriculum are Transformative Learning Theory and Social Constructivism.

Addendum’s to the MScOT Educational Conceptual Framework

Three addendums to our ECF have been developed. These follow the ECF, included in the next pages of this document.

1. The ECF and Indigenous Ways of Knowing
2. Updated reference list for the ECF
Addendum 1: The ECF and Indigenous Ways of Knowing

Brief Overview
In keeping with our values of diversity, inclusion, justice, equity, and accountability and with a desire to participate in a meaningful way in the process of reconciliation with Indigenous peoples, we aim to embrace Indigenous Ways of Knowing in our pedagogical approach. We respect the importance of these traditions, believe that they are necessary for all occupational therapists to know about, and add important perspectives to our program.

Although there has been some attention to indigenous and First Nations education in the program for decades, it has not been substantial. We are learning how to bring a broader range of understandings, and recognition of the diversity across many indigenous nations more fully into our curriculum and program, and are still in the early stages of this work.

We appreciate/recognize that there are similarities between approaches to occupational science and occupational therapy that can be seen as similar to Indigenous Ways of Knowing, and we are beginning to explore conceptual congruence more deeply, examining the implications for education, practice, research and knowledge sharing. We also recognize that there are significant differences between dominant occupational perspectives and indigenous ways of knowing (for example, learning from dreams). We are encouraged by these methods and how they challenge our entrenched ways of seeing the world.

Examples of some of the specific concepts seen in the curriculum are the belief/focus on holism and seeing individuals in context; the value of narrative to understandings of individual lives and of community life; approaches to learning that value meaningful engagement in experience (experiential learning); reflexive and reflective practices for teachers and learners, to deepen understandings of identity, position, and history; occupational understandings of health, quality of life, and well-being rather than/in addition to Western medical understandings of well-being; appreciation for life in urban, rural, remote and reserve locations; and learning through observation, including close listening and observation of the natural world. The traditional indigenous Medicine Wheel (Bell, 2014) and the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Polatajko, Townsend, & Craik, 2007) can be seen as complementary, and can be used together in classroom discussions and assignments.

An educator in the classroom or in fieldwork reflecting Indigenous Ways of Knowing will:

- Explicitly value holism and the integration of mind, physical body, spirit, and emotion within each individual, and in social contexts;
- Privilege oral traditions and narrative ways of knowing;
- Appreciate and promote non-pharmaceutical interventions such as strategies to promote social inclusion, traditional approaches to healing such as sweat lodges, and the therapeutic use of indigenous arts and crafts;
- Use a post-colonial lens to understand client-therapist interactions, and not expect indigenous clients to unquestioningly conform to the demands of systems based on Western medical/health care.

Specific examples of the influence of this approach in our curriculum include:

- Recruitment materials indicate via FAQs and statements that individuals of diverse backgrounds are encouraged to apply.
• Opportunities to dialogue with representatives from indigenous groups on topics related to historical analysis and theoretical approaches (e.g. cultural humility, cultural safety, cross-cultural competencies).

• Classes that explore a range of ontological and epistemological perspectives, including using post-colonial and privilege/anti-oppression analysis;

• Attention to cultural humility and cultural safety in professional formation and evaluation (e.g. fieldwork, research projects);

• Case studies based on indigenous individuals and communities;

• Readings and other resource material that demonstrate indigenous, narrative ways of knowing, and the integration of indigenous ways of knowing with other worldviews, such as Western medical science.

• Ensuring that all faculty, staff, and students are aware of, and encouraged to read and act on, the Truth and Reconciliation Report, including the Calls to Action for health professional education (Truth and Reconciliation Commission of Canada, 2015).

• Opportunities for international, Northern Ontario, role-emerging, and/or out of province placements in which students are exposed to indigenous populations and issues.

**Assessments coming from this perspective will:**

• Use narrative approaches (oral, graphic, and written)

**References**


Addendum 2: Additional References for the ECF


V. Curriculum Structure

Guiding Principle: The major elements of the MScOT program are organized in a logical sequence and in a coordinated and integrated manner that supports the progressive development of students’ competencies.

We understand that students enter the MScOT program with knowledge that stems from their particular cultural, religious, educational and social experiences and their individual personal attributes. The curriculum is designed to move students to a broader understanding of how the world works, to understanding the value of occupation in that world, and to seeing themselves as occupational therapists.

The flow of the curriculum structure is achieved through identified continua across the two years, guiding constructs and cross-cutting themes (see Figure 2, Program Structure and Flow). The predominant continuum, foundations to occupational enablement, incorporates two of the guiding constructs (occupation, client-centred enablement). In Year 1, the foundations for occupation are introduced within OCT1111Y (constructs and conceptual models) and OCT1141H (occupation-based assessments), and those for client-centred enablement within OCT1131H (practice contexts and approaches) and OCT1100H (technology in practice). These are supported by three courses providing foundational content for client-centred enablement (musculoskeletal, psychosocial and neuro-motor/neuro-cognitive perspectives. In Year 2, six courses integrate these concepts developing students’ expertise in enabling occupation. These six courses use the third guiding construct, the lifespan, as an organizing structure.

Individual components of the curriculum were developed to address foundational, application and skill development content reflecting the other five continua. These continua (basic to complex, generic to specific, teacher-driven to student-driven, novice to expert) are reflected within and across courses in the curriculum in the way course content (academic and fieldwork) is provided, communicated and evaluated (e.g., interactive lectures by professors to seminars by students) and in assignments (e.g., tests to individual papers).

A fundamental principle of the curriculum structure is maximization of integration of content. This is achieved in a number of ways.

1. Six major cross-cutting themes are emphasized with the curriculum: Professional accountability & leadership, research, reflexivity and mentorship, diversity and inclusion, sexuality and interprofessionalism. These are supported by courses and by content within and between courses.

2. Faculty of related courses are responsible for meeting to discuss how best to reduce overlap, fill gaps and coordinate course content related. For example, the course coordinators of courses with neuro-related content regularly share lecture and assignment content to ensure one course builds on what has and is happening in other courses (e.g., confusion around the concepts bottom-up / top-down and remediation, restoration and compensation has been reduced by this coordination).

3. The curriculum and course management system, Atlas, allows instructors to upload materials that should feed forward into other courses. These materials are then available to instructors teaching related materials.
4. Meetings are held pre- and post-term with course coordinators responsible for courses within the term to facilitate further integration. Term and year coordinators liaise with the Professional Curriculum Committee (PCC) to ensure this information is carried forward.

5. Student representatives to the PCC are asked to report to the PCC on all educational experiences that are perceived as redundant. This information is fed back to faculty. In turn, in instances in which the content is designed to build on what has gone previously, this information is fed back to students.

A second fundamental principle of the curriculum structure is **maximization of consistency**. This is a key role of the operations side of the PCC. Thus, components of the curriculum have predictable, patterned timelines in keeping with typical semesters. In addition, student study groups have consistent rooms in which to meet. This assists students and faculty in planning, integration and delivery of content. An overview each academic year of the important dates for each cohort of students (year 1 and year) is available online generally in August of each year ([http://ot.utoronto.ca/current/calendar/](http://ot.utoronto.ca/current/calendar/); see Appendix C for 2016/17 Academic Year Curriculum Overview and Dates). Term schedules are also available to students online ([http://ot.utoronto.ca/current/calendar/](http://ot.utoronto.ca/current/calendar/)) and well ahead of the term starting. Consistency within the curriculum is also provided via curriculum related policies (see Appendix B, *Curriculum Policies and Guidelines Handbook*). For example, policies on grading, course outlines and the assignment and evaluation of group work have been developed and are followed by all faculty. All policies are approved by the Departmental Advisory Committee prior to being included in the *Handbook*. 
VI:  Overview of the MScOT Fieldwork Program

Guiding Principles: The MScOT Fieldwork Program is designed to meet the standards set out in the Canadian Guidelines on Fieldwork Education for Occupational Therapy (CGFEOT) and those specified in the Minimum Standards for the Education of OTs, 2002 edition (World Federation of Occupational Therapists (WFOT)) and to facilitate the MScOT Program goals and objectives.

The MScOT Fieldwork Program meets the standards set out by the Committee on University Fieldwork Education (CUFE) of the Association of Canadian Occupational Therapy University Programs (ACOTUP), namely the ‘Canadian Guidelines on Fieldwork Education for Occupational Therapy (CGFEOT)’, and the ‘Minimum Standards for the Education of OTs, 2002 edition’ as outlined by the World Federation of Occupational Therapists (WFOT).

Fieldwork sites that have a signed Placement Agreement or Affiliation Agreement with the University of Toronto are accredited, and re-accredited at least every five years, by the Department through a process that includes completion of a Fieldwork Site Profile and a formal review of all student evaluations of the fieldwork site in the relevant time period. Student evaluations of fieldwork sites, done through a formal online evaluation, focus on the quality of the learning experience. The student and fieldwork preceptor(s) discuss these evaluations. They are also reviewed by the Department's Fieldwork faculty.

Fieldwork preceptors are required to be practicing occupational therapists that are registered with their provincial/regional regulatory organization and have at least one year of clinical experience. Preceptor education to improve and enhance clinical teaching is available by way of online resources and learning modules and workshops. Excellence in clinical education is recognized through various Departmental, university, and national awards. In addition, clinicians that provide annual fieldwork teaching are eligible for Status or Adjunct Lecturer positions within the Department.

Fieldwork Progression & Evaluation
Fieldwork placement opportunities focus on the development of student competencies rather than on students gaining experience with specific diagnostic group, age group, or practice area. As students progress through the fieldwork program, their learning objectives requiring more advanced clinical reasoning and increasing levels of independence. Fieldwork preceptors structure learning experiences to reflect the level of the placement.

Learning objectives for each fieldwork course are listed under the CBFE-OT competencies within each fieldwork course outline: each objective is linked to the OT Roles specified in the ‘Profile of practice of occupational therapists in Canada’ (Canadian Association of Occupational Therapists, 2012). The attainment of both the formal fieldwork objectives and personal learning objectives is evaluated by preceptors midway through and at the end of the course using the Competency Based Fieldwork Evaluation for Occupational Therapy (CBFE-OT) (Bossers, Miller, Polatajko & Hartley, 2007). Students keep copies of their CBFE-OT evaluations in their professional learning portfolio to outline the progression of their professional competencies.
Fieldwork Courses and Opportunities

Five courses provide fieldwork opportunities for students in the Department. In total, students complete 1,072.5 fieldwork hours within the Program.

1. OCT1131H: OT Practice 1: Included in this course is the Introductory Fieldwork Experience (six days within a 2-week period). In pairs, students spend three days each in two different practice contexts.

2. OCT1183Y: OT Fieldwork 1: This is the first of four ‘block’ placements. In Term 3, students spend six weeks (5 days/week) in a practice context.

3. OCT1281Y: OT Fieldwork 2: In Term 4, students spend seven weeks (5 days/week) in a practice context.

4. OCT1282Y: OT Fieldwork 3: In Term 5, students spend eight weeks (4 days/week) in a practice context.

5. OCT1283Y: OT Fieldwork 4: In Term 6, their final term in the Program, students spend eight weeks (5 days/week) in a practice context.

Core Fieldwork Requirements

To meet WFOT (2002) and CAOT standards, students are provided with a variety of opportunities across their fieldwork courses to ensure they gain experience across a diversity of settings, client populations and occupational performance issues. Specific requirements are:

- Completion of one fieldwork course (excluding OCT1131H) in physical health and one fieldwork course (excluding OCT1131H) in psychosocial health OR completion of two fieldwork courses (excluding OCT1131H) that combine physical and psychosocial health;

- Completion of fieldwork courses (excluding OCT1131H) in a minimum of two diverse practice settings (e.g. acute care, day hospital, rehabilitation services, community, long-term care);

- Completion of fieldwork courses (excluding OCT1131H) with a minimum of two different age groups practice settings (e.g. child, adolescent, adult, older adult);

- Completion of fieldwork courses (excluding OCT1131H) in a minimum of three different practice areas of practice (e.g. neurology, musculoskeletal, depression and anxiety disorders, rheumatology, etc.).

Completion of fieldwork requirements is tracked by the Department’s fieldwork office (via our Access database system) and by the individual student who is responsible for completing the online Fieldwork Matrix after each fieldwork course.

Other Out-of-Catchment Fieldwork Opportunities

Students have fieldwork opportunities throughout Ontario and in all other provinces of Canada. This includes funded placements in Northern Ontario organized through the Northern Ontario School of Medicine. These placements are arranged through the Department’s Fieldwork Coordinator.

International Fieldwork Opportunities

The well-developed International Fieldwork Program is coordinated by the Department’s International Fieldwork Coordinator. The Department has established relationships with a variety of international fieldwork partners that offer student placements. Students are informed of these opportunities in Term 1.

The Department has developed guidelines for the prioritization of international fieldwork opportunities and these guidelines are re-evaluated annually and shared with students. Current
priorities align with those of the International Centre for Disability and Rehabilitation (ICDR) (part of the Rehab Sector) at the University of Toronto (see www.icdr.utoronto.ca). These opportunities are in lower and middle-income countries that have established partnerships with ICDR and the Department. The Department’s International Fieldwork Coordinator sits on the ICDR Executive and is also a member of the CUFE International Fieldwork Group.

In addition to ICDR placements, the Department has fieldwork exchange agreements with a number of universities outside Canada, specifically in Australia, Holland, Hong Kong and Sweden.

In rare circumstances, students may arrange their own international fieldwork opportunity but must do so only with the permission and guidance of the International Fieldwork Coordinator and only if listed priority international fieldwork opportunities have been filled.

**Role-emerging and Role-enhancing Fieldwork Opportunities**

Fieldwork courses in terms 4, 5 and 6 (year 2) include opportunities for students identified as ‘role-emerging’ or ‘role-enhancing’.

Role-emerging opportunities are that that occur within an organization that does not presently employ an occupational therapist but could benefit from occupational therapy services. These opportunities are developed and coordinated by fieldwork faculty or by students who may submit a proposal for a role-emerging opportunity to the Role-emerging Fieldwork Coordinator. The fieldwork faculty arranges off-site supervision for the student and on-site supervision by a regulated health professional from another discipline.

Role-enhancing opportunities occur in organizations that employ occupational therapists and desire to enhance occupational therapy services within the organization. Students have opportunity to assist the organization in this aim through research, program planning, implementation, and/or evaluation of OT services.

**Interprofessional Education (IPE) within the Fieldwork Program**

As part of the IPE Program, MScOT students are expected to address competencies for IPE through participating in specific learning activities in clinical settings and, during their fieldwork courses, required to participate in a Structured (student team) IPE Placement OR to complete three Flexible IPE Activities (e.g., participation in a team education session; Interview and shadow two team members from other disciplines; participate in team meetings).
VII. Interprofessional Education Curriculum

Guiding Principles: The Interprofessional Education Curriculum is designed from the Framework for the Development of Interprofessional Education Values and Core Competency and to address the roles of Collaborator and Communicator as described in the Profile of Occupational Therapy in Canada (2012). These descriptions align with the competencies of the University of Toronto IPE curriculum.

Leadership and Oversight
The Centre for Interprofessional Education provides leadership for the IPE curriculum (http://www.ipe.utoronto.ca/). The Mission of the Centre is to provide health professional students with the core competencies needed for the provision of interprofessional, evidence-based care in a collaborative, team practice environment, and to further establish the University of Toronto (UT), the University Health Network (UHN), and partners as a national and international leader in interprofessional education.

The Centre for Interprofessional Education curriculum team is responsible for the development, implementation and evaluation of the IPE curriculum. Team members include: the Faculty Lead IPE Curriculum and Scholarship (0.5FTE) (Prof. Sylvia Langlois, Assistant Professor, Occupational Science and Occupational Therapy), a Strategic Lead of IPE Curriculum (0.5FTE), a Process Lead of IPE curriculum (0.7FTE), an Education Coordinator (1.0FTE) and an Administrative Assistant (0.7FTE).

The IPE curriculum has input through all health professional program via the InterFaculty Curriculum Committee. This committee, with representatives from each of the eleven health profession programs (Dentistry, Kinesiology and Physical Education, Medical Radiation Sciences, Medicine, Nursing, Pharmacy, Physical Therapy, Physician Assistant, Social Work and Speech-Language Pathology), the Centre of Interprofessional Education and students from the Interprofessional Health Science Student Association, meets monthly to discuss the IPE Curriculum. Agenda items include curriculum direction, development, logistical issues, integration into program courses and evaluation.

The Council of Health Sciences (representing Deans, Chairs and leaders from each of the eleven programs) provides oversight and governance: Leaders from the Centre provide regular presentations to the Council.

IPE Curriculum Progression
The IPE curriculum is built on the Framework for the Development of Interprofessional Education Values and Core Competency (2009, reviewed 2016, see Figure 3), addressing core constructs of Values and Ethics, Communication and Collaboration.

Requisite Core Learning Activities:
1. First Year:
   - Teamwork: Your Future in Healthcare (includes completion of Introductory IPE modules and test)
   - Roles of Health Professions and Team Dynamics
   - Understanding Patient/Client Partnerships
   - One additional core learning activity has been approved by the Council of Health Sciences and is currently being planned for implementation in March of 2018.
2. Second Year:
   - Quality and Safety
Elective Learning Opportunities:
The Centre for Interprofessional Education has approved and manages approximately 180 elective learning activities (see http://www.ipecurriculum.utoronto.ca/ for details). Approximately half of the activities are offered at the university and half are offered at local teaching hospitals. These activities are developed and implemented through partnerships among the curriculum team at the Centre, university faculty representatives and clinical IPE leaders. These learning activities draw from a pool of more than 1000 trained facilitators who are committed to working with students as they develop collaborative competencies. Each of these activities has gone through a Centre managed approval process (Points for Interprofessional Education - http://www.ipe.utoronto.ca/curriculum/elective-approval-process-pipes/pipes-information-package).

In addition, three certificate programs have been offered since 2013 with an enrollment limit of 90 students: Interprofessional Management of Chronic Health Challenges, Interprofessional Quality and Safety and Interprofessional Health, Arts and Humanities. In spring 2017, 11 MScOT students received certificates in one of the three programs.

Communication with Students:
Students receive weekly emails informing them of upcoming learning opportunities. They register for the activities through an online registration system set to ensure an appropriate mix of professions represented.

Tracking of Completed IPE Learning Activities
All completed learning activities are entered into a database that both students and corresponding faculty can access. All students receive a Letter of Completion or Letter of Distinction (completion of more than two learning activities above the program requirements) upon meeting all IPE program requirements. In 2016, 50 MScOT students received a Letter of Distinction.

Leadership Opportunities for Students
These opportunities are available to all health profession students.

- Student Facilitator Program: Students attend a workshop (similar to one offered by the Centre for Faculty Development): following completion they are assigned two facilitation opportunities in which they practice their interprofessional facilitation skills and receive feedback from an experienced facilitator.
- Small Group Facilitation: There are many opportunities throughout the IPE curriculum for students to practice interprofessional facilitation of small groups. They receive additional training and support as needed for specific learning activities.
- Curriculum Working Groups: The IPE curriculum team values the input from learners. Students have the opportunity to co-create curricular activities with faculty and patient educators/advocates.
- Interprofessional Health Science Student Association (IPHSA): The IPHSA group is active and has approximately 45 leadership positions, including executive and sub-group roles. IPHSA is
represented on the InterFaculty Curriculum Committee and meets regularly with the curriculum team. For the 2016/17 academic year a second year MScOT student has volunteered to sit on the InterFaculty Curriculum Committee.

**Leadership Recognition**
The Susan J. Wagner Student Leadership Award in Interprofessional Education is awarded to a graduating student who has demonstrated leadership, dedication and excellence through promotion and engagement of interprofessional education and care. In 2016, an MScOT student received this award.

**Ongoing Curriculum Revision**
Students in the MScOT 2016 cohort will participate in a pilot of a new certificate program in 2017/18. These categories for these are: mental Health, Aging, Indigenous Health, and Chronic Health Challenges. Students, working on small teams through a term, will be mentored by faculty and a patient educator/advocate and then present their results at a showcase event. On completion and evaluation of this pilot, the Centre for IPE will determine expansion plans.

**Assessment**
The following assessments are integrated into course requirements in the MScOT curriculum:
- Online quiz following completion of the Introductory IPE Modules
- Four IPE reflective papers on the following topics: #1: Understanding Patient/Client Partnerships in a Team Context; #2: Interprofessional Values and Ethics; #3: Interprofessional Communication; #4: Interprofessional Collaboration.
- Interprofessional Collaborator Rubric Assessment: Students provide formative feedback to their peers during the Pain Curriculum in which they spend eight-nine hours working in small groups.
- Interprofessional Competence Assessment: This is being piloted with senior students in practice during their final placement. The assessment has been developed at the University of Toronto and is undergoing validation for broader dissemination.
- Final portfolio assignment in the Building Practice through Mentorship course addresses development of the Collaborator and Communicator competencies

**IPE Curriculum Evaluation**
The following evaluation components are currently in place:
- Students complete evaluations of all learning activities
- IMPACT Study: This study, led by the University Health Network and Holland Bloorview Kids Rehabilitation Hospital in conjunction with the Centre for Interprofessional Education, will explore the impact of the IPE curriculum on learners in practice.
- IPHSA Student Led Survey: IPSHA sends a survey to all health profession students to gather feedback on their organization and student satisfaction with the IPE curriculum. Although the response rate is typically low, the Centre for Interprofessional Education and the InterFaculty Curriculum Committee review all feedback.
- An IPE Curriculum evaluation plan is being developed with an evaluation consultant and will be implemented in the fall of 2017.
VIII: Curriculum Evaluation

Guiding Principle: The MScOT program’s curriculum management and evaluation processes are designed to ensure that continuous quality improvement is occurring in order to ensure continued excellence.

The Curriculum Evaluation Plan (see Figure VIIa) is an iterative, multi-component process that includes formal structures and formal reporting lines but also allows interaction between any of the five boxes as indicated by the 5-point arrow in the centre of the Figure.

Figure VIIIa. Curriculum Evaluation Plan

The curriculum evaluation process is based on five key principles that it must:

1. Be both formative and summative;
2. Occur informally and formally;
3. Take place routinely on many levels: by the department as a whole, by the Professional Curriculum Committee (PCC), by subgroups of and individual faculty, and by students;
4. Evaluate the curriculum as whole and evaluate components;
5. Consider and reflect multiple perspectives including those of the faculty, clinical affiliates, students, and graduates.

The time-frame and components of the curriculum evaluation plan are depicted in the Figure. Table VI.1 organizes the components of the curriculum evaluation plan according to whether they are summative or formative and by the stakeholder group providing the evaluation. As the curriculum is integral to the Program meeting its overarching goal and objectives, summative evaluations of the Program are the primary sources of summative evaluations of the curriculum. These are described in
Section VII of this document. Additional summative evaluation components of the curriculum are those that relate to whether specific courses have met their objectives and are serving their function within the overall curriculum structure.

Table VIII.1 Curriculum evaluation components provided by multiple stakeholders

<table>
<thead>
<tr>
<th>Stakeholder providing evaluation</th>
<th>Formative</th>
<th>Summative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students</td>
<td>• Course evaluations</td>
<td>• Course evaluations – specific questions are summative in nature, e.g., did the course meet its objectives.</td>
</tr>
<tr>
<td></td>
<td>• Student input to PCC and SAC</td>
<td>• Year 1 completion and graduating student exit surveys</td>
</tr>
<tr>
<td></td>
<td>• Year 1 completion and graduating student exit surveys</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Informal surveys done in class and/or by students to address specific issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Informal feedback given in class, privately to the instructor or to the chair, and through conversation with faculty advisors.</td>
<td></td>
</tr>
<tr>
<td>Alumni</td>
<td>• Alumni longitudinal survey (starting May 2017)</td>
<td>• Alumni longitudinal survey.</td>
</tr>
<tr>
<td>Core Faculty</td>
<td>• Formal and informal feedback provided through term meetings, SAC, PCC, and DAC.</td>
<td>• Formal and informal feedback provided through term meetings, SAC, PCC, and DAC.</td>
</tr>
<tr>
<td>Clinical Community</td>
<td>• CBFE evaluations (record students' developmental progression through program)</td>
<td>• CBFE evaluations (number of students passing fieldwork placements)</td>
</tr>
<tr>
<td></td>
<td>• Informal feedback provided via community representatives on SAC, PCC, GTA OT Practice Leader Network, and Fieldwork Advisory Committee</td>
<td>• Informal feedback provided via community representatives on SAC, PCC, GTA OT Practice Leader Network, and Fieldwork Advisory Committee</td>
</tr>
<tr>
<td>CAOT</td>
<td>• 5-year trend analysis of U o T performance across competencies on CAOT exam (NOTCE)</td>
<td>• CAOT certification exam results (NOTCE)</td>
</tr>
<tr>
<td>External OT community</td>
<td>• Cyclical Program Reviews provide formative and summative feedback on the program. For example, in the most recent review, reviewers noted the importance of ensuring new areas of learning pertinent to OS &amp; OT are integrated into the curriculum (formative).</td>
<td></td>
</tr>
</tbody>
</table>

Legend: PCC=Professional Curriculum Committee; SAC=Student Advisory Committee; DAC=Departmental Advisory Committee.
IX. Program Evaluation

**Guiding Principle:** *The Program evaluation process is designed to be both formative and summative; occur informally and formally; take place routinely and on many levels; evaluate the program as whole and evaluate components; and consider and reflect multiple perspectives.*

The program evaluation plan is documented and represented in the Program Logic Model (see Figure 1) and the Program Evaluation Time-Frame & Responsibility Table (see Table VIII.1). Program evaluation includes (1) Process Outputs, (2) Short-term Outcome Objective Indicators, and (3) Long-term Outcome Objective Indicators.

### Table IX.1 Time-frame and Responsibility for Program Evaluation

<table>
<thead>
<tr>
<th>Time</th>
<th>Process Outputs</th>
<th>Short-term Outcome Objective Indicators</th>
<th>Long-term Outcome Objective Indicators</th>
</tr>
</thead>
</table>
| Each Term             | • Term & Year Coordinator  
                        • Student reps to PCC & SAC  
                        • Faculty reps to PCC & SAC  
                        • Marks Evaluation Meeting  
                        • Evaluations of IPE events  
                        • ATLAS reports  
                        • Informal feedback through GTA OT Practice Leader Network | • Course evaluations (questions related to course contributing to overall learning)  
                        • Students’ Professional Portfolio  
                        • IPE evaluations  
                        • Informal feedback through the GTA OT Practice Leader Network | • Informal feedback through the GTA OT Practice Leader Network |
| Ad-Hoc                | • Informal surveys of students, faculty and other stakeholders                    | • ATLAS reports                                                                                       |                                                                                                          |
| Bi-Annual & Annual    | • Annual Curriculum Retreat  
                        • Fieldwork Advisory Committee  
                        • Theme Groups (Leadership, Diversity & Inclusion, Big Health...)  
                        • IPE Annual Report on OT student satisfaction across events | • Students’ Professional Portfolio  
                        • CAOT Certification Exam (NOTCE)  
                        • Fieldwork Advisory Committee  
                        • Student Exit Surveys  
                        • Alumni Longitudinal Survey  
                        • IPE Annual Report  
                        • IPE assignment related to Students’ Professional Portfolio  
                        • IPE developmental assessment of student competencies | • CAOT Certification Exam (NOTCE)  
                        • Fieldwork Advisory Committee  
                        • Alumni Longitudinal Survey |
| Up to every 7 years   | • CAOT Accreditation                                                           | • Alumni Longitudinal Survey  
                        • CAOT Accreditation  
                        • Departmental External Reviews | • Alumni Longitudinal Survey  
                        • CAOT Accreditation  
                        • Departmental External Reviews |

Evaluation data are used on an ongoing basis by the Chair, Executive, Vice-Chair, Education and PCC for curriculum renewal. The Vice-Chair, Education (new position as of January 2017) is anticipated to
provide a comprehensive report synthesizing all evaluation materials every five years. The Vice-Chair, Education along with the faculty member providing oversight to the Atlas activities will also provide recommendations to the Chair and faculty regarding how data should be input to best serve evaluation purposes.

To further elaborate the program evaluation process, Table VII.2 shows the multiple stakeholders who provide evaluation important to determination of whether the Department is meeting its goal and objectives.

Table IX.2: Program evaluation components provided by multiple stakeholders

<table>
<thead>
<tr>
<th>Stakeholder providing evaluation</th>
<th>Type of Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Formative</strong> (Feedback provided to foster development and improvement)</td>
<td><strong>Summative</strong> (Does the program meet its goals and objectives)</td>
</tr>
<tr>
<td>Students</td>
<td>● Process outputs: For example, student evaluations of fieldwork site, course evaluations, term feedback provided to PCC and SAC, feedback provided on exit surveys. Informal process output is provided through opportunities by faculty within courses (e.g., via i-clicker survey), informal feedback given in class, privately to the instructor or to the chair, and through conversation with faculty advisors.</td>
</tr>
<tr>
<td>Core Faculty</td>
<td>● Formal and informal feedback provided through term meetings, SAC, PCC, and DAC.</td>
</tr>
<tr>
<td>Clinical Community</td>
<td>● CBFE evaluations (record students’ developmental progression through program) ● Informal feedback provided via community representatives on SAC, PCC, GTA OT Practice Leader Network, and Fieldwork Advisory Committee</td>
</tr>
<tr>
<td>CAOT</td>
<td>● 5-year trend analysis of U o T performance across competencies on CAOT exam (NOTCE)</td>
</tr>
<tr>
<td>External OT community</td>
<td>● Cyclical Program Reviews provide formative and summative feedback on the program. For example, in the most recent review, reviewers noted that admission requirements were consistent with the mission of the Department (summative) and the importance of ensuring new areas of learning pertinent to OS &amp; OT are integrated into the curriculum (formative).</td>
</tr>
</tbody>
</table>

Legend: PCC=Professional Curriculum Committee; SAC=Student Advisory Committee; DAC=Departmental Advisory Committee.

The Alumni Longitudinal Survey (see Appendix D) developed in 2016 will be implemented in May 2017 to survey 2016 graduates six months post-convocation. Our intent is to survey graduates at the following time intervals: 6 months, 18 months, 4 years and 5 years. Graduates completing a survey will receive a credit that can be used for courses offered by the department through Continuing Education.
REFERENCES


### Figure 1: Program Logic Model

#### Department of Occupational Science and Occupational Therapy
**MScOT Program Logic Model** (Aug 31, 2015: Revised March 2017)

**Philosophy, Values and Theories** underpinning the Educational Conceptual Framework inform and are reflected in the Main Components of the Program. (Educational Conceptual Framework, 2012)

<table>
<thead>
<tr>
<th>Main Components</th>
<th>Fieldwork</th>
<th>Interactional Lectures</th>
<th>Case Classes</th>
<th>Skills Labs &amp; Experiential Learning</th>
<th>Inter-Professional Education</th>
<th>Mentorship, Small Study Group and Peer Learning</th>
<th>Evaluations</th>
<th>Leadership Opportunities</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Objectives</td>
<td>Processes undertaken to fulfill the components e.g., recruit mentors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Complete 5 fieldwork experiences at accredited sites</td>
<td>• provide opportunities for large group learning of foundational concepts, theories, models</td>
<td>• provide real life case based learning scenarios of increasing complexity and challenge</td>
<td>• Provide opportunities for hands on learning</td>
<td>• Provision of 5 mandatory number of IPE sessions of varying levels and content</td>
<td>• Provide structured mentor groups</td>
<td>• provide a variety of evaluations including written, oral, examination, individual and small group</td>
<td>• Provide opportunities for student representation on committees</td>
<td>• Completion of 4 research courses</td>
</tr>
<tr>
<td></td>
<td>• Experience in a variety of practice areas</td>
<td>• facilitate critical thinking skills</td>
<td>• integrate theory with practice</td>
<td>• expose to a diversity of perspectives and world views</td>
<td>• Create “disorienting experiences”</td>
<td>• Ensure opportunities for study group peer learning</td>
<td>• Require submission of research abstracts to peer-reviewed conferences</td>
<td></td>
<td>• Encourage research publication</td>
</tr>
<tr>
<td></td>
<td>• Develop Learning contract/objectives</td>
<td></td>
<td>• Engage expert guest lectures to co-facilitate</td>
<td></td>
<td>• Facilitate skill development of assessment and enabling strategies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Outputs</td>
<td>Data about program activities e.g., type &amp; # of activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>• Student evaluation of site</td>
<td>• # and type of interactional lectures</td>
<td>• # and level of complexity of cases</td>
<td>• # and types of skills labs</td>
<td>• # and types of IPE hours/colours reflections</td>
<td>• # and types of leadership opportunities created</td>
<td>• Mentor groups (Ihours, variety, content) – leadership</td>
<td>• # and types of evaluations</td>
<td>• # student reps</td>
</tr>
<tr>
<td></td>
<td>• Competency mapping</td>
<td>• # and details of foundational knowledge</td>
<td></td>
<td>• # and types of skills labs</td>
<td>• # and types of leadership opportunities created</td>
<td></td>
<td>• Study groups (Ihours)</td>
<td></td>
<td>• committees with student representation</td>
</tr>
<tr>
<td></td>
<td>• fieldwork experiences</td>
<td></td>
<td></td>
<td>• # and types of IPE hours/colours reflections</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• # and types of other leadership opportunities created</td>
</tr>
<tr>
<td></td>
<td>• Variety of fieldwork experiences</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Process Outputs</td>
<td>Data about stakeholder satisfaction</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Student satisfaction with all components obtained through course evals &amp; informal feedback</td>
<td>• Annual Faculty Assembly</td>
<td>• Term instructor satisfaction provided at term instructor meetings and PCC</td>
<td>• Learnings from other reports, e.g., external reviews.</td>
<td>• Student rep reports to SAC &amp; PCC</td>
<td>• Reports of student satisfaction from other surveys (e.g., U or T survey)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-term Outcome Objectives</td>
<td>Professional: Improve ethical practice and develop high personal standards of behaviour.</td>
<td>Practice Manager: Improve ability to manage time, prioritize, and support the management of effective and efficient practice.</td>
<td>Change Agent: Develop expertise to advance occupation and occupational performance, and engagement.</td>
<td>Expert in Enabling Occupation: Increase use of evidence-based processes that focus on clients’ occupations as a medium for action and outcome.</td>
<td>Communicator: Enhance oral, written, non-verbal and electronic communication.</td>
<td>Collaborator: Improve ability to work effectively with key stakeholders to enable participation in occupations by using and promoting shared decision-making approaches.</td>
<td>Scholarly Practitioner: Increase use of critique, reflection, and quality improvement in everyday practice through lifelong learning; Improve the facilitation of learning with clients, team members and other learners.</td>
<td>Leadership: Develop leadership skills to supervise support workers, assume management roles, and become leaders in the profession; Develop entrepreneurial skills.</td>
<td></td>
</tr>
<tr>
<td>Short-term Outcome Objectives Indicators</td>
<td>1. CBFET score average; 2. CAOT exam aggregate scores; 3. Number of students passing and aggregate scores on all competency-identified assignments; 4. Mentorship Portfolio</td>
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<tr>
<td>Long-term Objective</td>
<td>To create knowledge and prepare leaders in occupational science and occupational therapy to improve health and well-being locally and globally.</td>
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</tr>
<tr>
<td>Long-term Objective Indicators</td>
<td>1. Alumni Longitudinal Survey; 2. CAOT Accreditation; 3. Departmental External Reviews</td>
<td></td>
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</tbody>
</table>
### Figure 2: MSoOT Program Structure & Flow

<table>
<thead>
<tr>
<th>Term 1</th>
<th>Term 2</th>
<th>Term 3</th>
<th>Term 4</th>
<th>Term 5</th>
<th>Term 6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Foundations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Occupational Enablement</td>
</tr>
<tr>
<td>Basic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Complex</td>
</tr>
<tr>
<td>Generic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Specific</td>
</tr>
<tr>
<td>Teacher-Driven</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Student-Driven</td>
</tr>
<tr>
<td>Notice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Expert</td>
</tr>
</tbody>
</table>

#### Courses

**Foundation Courses**
- OCT112Y: Occupational Science: Foundations for Occupational Therapy
- OCT112Y: Assessment in Occupational Therapy
- OCT112Y: Macromolecular Structure and Function
- OCT112Y: Psychological Perspectives in OT
- OCT112Y: Neuro-motor/Neuro-cognitive Perspectives in OT

**Enabling Courses**
- OCT112Y: Enabling Occupation with Children Part 1
- OCT112Y: Enabling Occupation with Children Part 2
- OCT112Y: Enabling Occupation with Adults Part 1
- OCT112Y: Enabling Occupation with Adults Part 2
- OCT112Y: Enabling Occupation with Older Adults Part 1
- OCT112Y: Enabling Occupation with Older Adults Part 2

**Fieldwork Courses**
- OCT112Y: Introductory Fieldwork Experience
- OCT112Y: Occupational Therapy Fieldwork I
- OCT112Y: Occupational Therapy Fieldwork II
- OCT112Y: Occupational Therapy Fieldwork III
- OCT112Y: Occupational Therapy Fieldwork IV

#### Crosscutting Themes (NB: some themes are supported by courses, others by content within & between courses)

**Professional Accountability & Leadership**
- OCT112Y: OT Practice I: Specific accountabilities in documentation, ethics, supervision of support personnel
- OCT112Y: OT Practice II: Program development and evaluation and, focus on role emerging and community placements
- OCT112Y: OT Practice III: Themes picked up in Fieldwork and enabling courses through terms 4, 5, and 6.

**Research**
- OCT112Y: Research Issues and Practice in OT
- OCT112Y: Methods in Practice-based Research
- OCT112Y: Framing Practice-based Research
- OCT112Y: Graduator Research Project

**Reflexivity & Mentorship**
- OCT112Y: Building Practice through Mentorship

#### Diversity & Inclusion

- Orientation session: introduction to values placed on diversity and inclusion
- Workshop in OCT112Y on Indigenous Ways of Knowing
- Critical disability perspectives
- Class in OCT112Y: Guidelines for Intersectional Dialogue
- Class in OCT112Y: Marginalized Voices: aging, occupation and diverse identities
- Cross-cultural considerations with narrative interviewing
- Class in OCT112Y: Reflections on diversity issues in practice and content in OCT112Y & 127Y: Diversity in Context

#### Sexuality

- Class in OCT112Y: Introduction to Gender and Sexuality, disability and sexuality
- Class in OCT112Y: Ethics, consent and sexuality issues, PLSSY system
- Class in OCT112Y: Sexuality and gender considerations with marginalized communities (LGBT; diverse aging with cognitive impairment; age-related health conditions/plans/medications and sexuality, applying PLSSY system
- Class in OCT112Y: Sexuality and children with developmental disabilities
- Class in OCT112Y: Sex Toys, & Positioning
- Class in OCT112Y: HIV, sexuality and aging

#### Inter-professionalism

- Partnerships with Patients/ Clients in a Team Context (2016 cohort)
- Completion of one of the three IPE flexible learning activities in practice settings (structured IPE placements are also available for 2016 students)
- Quality and Safety (2016 cohort)
- Conflict in Interprofessional Life (2016 cohort)
- Palliative Care Case-Based Discussion (2016 cohort)
- 3-day Inter-Faculty Pain Curriculum
- Completion of one of the three IPE flexible learning activities in practice settings (structured IPE placements are also available for some students)
A Framework for the Development of Interprofessional Education Values and Core Competencies
Health Professional Programs, University of Toronto

EXPOSURE: Introduction
Knowledge
- Describe the role, responsibilities, and ethical considerations of the healthcare team and other healthcare professionals.
- Develop an understanding of the ethical issues within the healthcare team and how they may influence the team's decision-making.

Skill/Behavior
- Actively engage in ethical decision-making within an IP team.
- Support the team's decision-making process by actively participating and providing feedback.
- Demonstrate an understanding of ethical issues within the healthcare team.

Attitude
- Value the importance of ethical decision-making and actively participate in the team's decision-making process.
- Demonstrate an understanding of ethical issues within the healthcare team.

IMMERSION: Development
Knowledge
- Understand the importance of ethical decision-making within the healthcare team and its impact on patient outcomes.
- Recognize the ethical dilemmas faced within the healthcare team and how they may influence the team's decision-making.
- Reflect on ethical decision-making within the healthcare team.

Skill/Behavior
- Participate in ethical decision-making within the healthcare team.
- Support the team's decision-making process by providing feedback and suggestions.
- Demonstrate an understanding of ethical issues within the healthcare team.

Attitude
- Value the importance of ethical decision-making and actively participate in the team's decision-making process.
- Demonstrate an understanding of ethical issues within the healthcare team.

COMPETENCE: Entry-to-Practice
Knowledge
- Understand the importance of ethical decision-making within the healthcare team and its impact on patient outcomes.
- Recognize the ethical dilemmas faced within the healthcare team and how they may influence the team's decision-making.
- Reflect on ethical decision-making within the healthcare team.

Skill/Behavior
- Participate in ethical decision-making within the healthcare team.
- Support the team's decision-making process by providing feedback and suggestions.
- Demonstrate an understanding of ethical issues within the healthcare team.

Attitude
- Value the importance of ethical decision-making and actively participate in the team's decision-making process.
- Demonstrate an understanding of ethical issues within the healthcare team.

Reflection, Learning, and Formative Assessment
Learning Continuum
MScOT Educational Conceptual Framework, 2012

Preamble:
In response to the CAOT Accreditation Report (March 2011) of the Department of Occupational Science & Occupational Therapy (Department), and in conjunction with the development of a new Strategic Plan for the Department (October 2011), an ad-hoc sub-committee1 of the Professional Curriculum Committee was struck in September 2011 to articulate the Department’s educational conceptual framework. This document was prepared by the ad hoc sub-committee, in consultation with all core faculty members and with students and community faculty representatives on the Professional Curriculum Committee.

The University of Toronto’s MScOT Educational Conceptual Framework addresses the why and how of the curriculum we use to educate students to become occupational therapists. In addition to providing a framework for teaching and learning, the document provides a guide for the renewal of both academic and fieldwork course content and teaching processes. The framework will evolve with new evidence on educational theory and instructional design and with the insights gained by faculty and students. As educators who aim to model reflective practice, instructors are encouraged to discuss their implementation of theory in their course contents and teaching processes with their students.

Our educational conceptual framework builds on the Structure and Flow White Papers (Hall et al., 2001; Cockburn et al., 2007; Dawson, Cockburn & Davies, 2010), and the mission of our Department (2011):

Create knowledge of occupation and its enablement, and prepare leaders in practice, research and scholarship to improve the health and well-being of individuals and communities, locally and globally.

In addition to the resources referenced in this document, we also drew on the results of “Curriculum Conversations” held throughout May-June 2011 with core and status faculty to elicit a broad spectrum of views regarding the curriculum, and on open-ended conversations with key informants, including Professor Sylvia Rodger, Head of Occupational Therapy, University of Queensland and author of Good practice guides and cases to support curriculum development and renewal in occupational therapy (2011). The University of Toronto’s MScOT Educational Conceptual Framework was ratified by the faculty at the May 2012 Curriculum Retreat.

1 Committee members and authors: Deirdre Dawson (Chair), Barry Trentham, Lynn Cockburn, & Gail Teachman.
Overview:

The University of Toronto’s MScOT Educational Conceptual Framework consists of a definition, a philosophy and values statement, a description of the key learning theories that provide the foundation to our curriculum, and examples of how this framework guides the curriculum as a whole, as well as decision-making regarding prerequisites, course content, instructional methods, and the evaluation of student learning.

Definition:

The MScOT Educational Conceptual Framework is an explicit representation of our educational philosophy, including the concepts, constructs, principles, values, beliefs, and theories that inform our approaches to teaching, learning, curriculum development, curriculum renewal, and the relationships between these.

Philosophy & Values:

We believe that:

- Learning is a life-long, interactive and transformative process.
- Flexible, student-centred pedagogies are critical for developing and fostering leaders.

And that the role of an educator is to:

- inspire
- inform
- challenge
- support
- model
- stimulate problem solving, reflexivity, and critical thinking
- collaboratively discover new knowledge with students

In educating occupational therapists we value:

- excellence, innovation, leadership, collaboration, partnership, occupation, justice, equity, diversity, inclusion, client and family-centredness, integrity, accountability, transparency, life-long learning, critical inquiry, and professionalism

Our purpose is to:

- prepare leaders in occupational therapy practice, research and scholarship to improve the health and well-being of individuals and communities, locally and globally
- ensure that occupational therapy graduates have the knowledge, attitudes, and skills necessary to enable the occupational engagement of all citizens
We expect University of Toronto MScOT students to:
• engage in and be transformed by the learning process
• actively contribute to the educational process by teaching and learning from each other
• mobilize their professional education as change agents at the micro, meso and macro levels of society through practice, research and scholarship in occupational science and occupational therapy

We acknowledge tensions inherent between some of the values and beliefs we hold, and we actively study these tensions to stimulate learning and creativity among faculty and students. Tensions also arise from competing philosophies on the purpose of education. For example, an essentialist\(^2\) educational approach emphasizes educating competent therapists by means of transmitting expert knowledge, which conflicts with the premises of constructivist and transformative learning theories. These latter theories embody philosophical perspectives that value learning as a transformative experience. In these theoretical perspectives the role of educators is to enable learners to be independent problem solvers who appreciate and address the social issues that support or limit the occupational performance and engagement of individuals, communities and populations. We recognize and respect that students come from different academic and cultural backgrounds, are at different stages of learning, have different goals, and will vary in their ability to learn, integrate and reflect on the content within the MScOT curriculum.

Theories on Learning:

Mezirow’s transformative learning theory (1991) is foundational to our MScOT educational conceptual framework, and within this overarching approach we draw on Merriam and Caffarella’s social constructivism (1999), Giroux’s (2010) and Shor’s (1996) critical pedagogy, Kolb’s theory of experiential learning (1984), Mergel’s cognitive neuroscience theory (1998), and Bloom’s taxonomy of learning (Bloom et al., 1956). As learning may be understood as an occupation (or a process that incorporates many occupations), we view the learning process as being influenced by person level performance components (cognitive, affective, physical and spiritual in both educators and students), environmental level performance components (physical, institutional, cultural and social) and by the characteristics of the specific learning activity. Some theories explain person level processes (e.g., cognitive neuroscience theories), while others emphasize the environmental aspects of learning (e.g., social constructivism). Bloom’s taxonomy characterizes learning activities. We recognize that these theories have overlapping principles (e.g., the need for reflecting on experience) and span several aspects of learning. While our courses incorporate strategies from several of these theories, we frame our curriculum on the overarching principles of transformative learning theory.

\(^2\) Essentialist education philosophy assumes that people learn through the transmission of expert knowledge by a more knowledgeable instructor where there is a focus on techniques and products. Teachers following this approach would provide presentations, demonstrations and modeling (McNay, 2009). A commonly used analogy for this type of teaching is the image of the student as an empty vessel, which the teacher fills with her/his knowledge.
TRANSFORMATIVE LEARNING THEORY

Brief Overview:
Transformative learning theory focuses on ‘deep learning’, that is, learning that occurs with a significant shift in meaning perspectives or in the system of shared beliefs that individuals use to make sense of lived experience (Mezirow, 1991). Transformative learning theory is based on adult learning theory and is grounded by similar theoretical principles and hypotheses (Knowles, 1984):

1. Self-Concept: As individuals mature, they move from dependency to self-directedness.
2. Experience: Adults draw upon their experiences to aid their learning.
3. Readiness: Motivation to learn is influenced by the adoption of new social roles where new learning is required.
4. Orientation: As new knowledge is gained, the adult learner is motivated to apply it in relevant situations where problem solving or new skills are required.
5. Motivation: As a person matures, she or he is motivated to learn from internal factors.

The transformative learning lens we have adopted as a faculty means that we understand that our students enter the MScOT program with knowledge that stems from their particular cultural, religious, educational and social experiences and their individual personal attributes. Our curriculum is designed to move our students to a broader understanding of how the world works, to understanding the value of occupation in that world, and to seeing themselves as occupational therapists. This is achieved by actively engaging the students in queries regarding how we know what we know, and explicit questioning of accepted views of power and authority. Fundamental shifts in their consciousness may occur resulting in new views of family, work, society and the world at large. Theorists of transformative learning suggest that the learner’s capacity for compassion, understanding, tolerance and acceptance is greatly expanded using this approach, leading to new ways of interacting with family, work and society (Mezirow, 2000). We strive to ensure our curriculum is truly transformative, and that these changes in consciousness lead to significant changes in our graduating students’ actions.

Transformative experiences are more likely to occur when learners gain experiences that are beyond their usual social location. Our fieldwork, in particular, provides opportunities in which students can be immersed in other cultures. We devote substantial resources to providing our students with cross-cultural learning opportunities both within and outside of Canada. Other examples of how transformative learning theory is implemented in our curriculum are given below. In addition, we provide examples of how educators reflect this theory in their teaching and assessments.

An educator in the classroom or in fieldwork using Transformative Learning Theory will:
- engage learners in the examination of diverse sources of information that may influence their worldview and belief system
- establish an environment that builds trust and care and facilitates development of sensitive relationships among learners (Taylor 1998)
- create a “community of knowers”, individuals who are “united in a shared experience of trying to make meaning of their life experience” (Loughlin, 1993, pp. 320-321)
• model willingness to learn and change by expanding and deepening her/his own understanding of, and perspectives about, subject matter and teaching approaches (Cranton, 1994)
• model critical self-reflection regarding the belief systems that inform her or his own actions
• promote and enable dialogue on diverse student perspectives to elicit critical reflection
• problematize commonly accepted terms or conventions, e.g., medical versus social models of disability, and the assumptions behind strategies such as chronic disease self-management
• implement varied approaches in the classroom to convey the lived experience of potential users of occupational therapy, e.g., arts-informed methods such as narrative, drama, video, documentary and photographic images that lead to an expanded frame of reference for students
• model the critical examination of evidence, e.g., evidence on neurodevelopmental treatment, or factors that predict return to work outcomes following traumatic brain injury
• discuss how the social determinants of health challenge assumptions about disease causality
• acknowledge that the experiences of learners relate to real life situations

Specific examples of the influence of Transformative Learning Theory in our curriculum include:
• students identifying changes in their clinical reasoning during case-based discussions, as well as documenting changes in their clinical reasoning across the program in their portfolios
• students gaining different perspectives through panels of individuals with diverse abilities, ethno-cultural backgrounds and other characteristics
• students’ development of guidelines for transcultural dialogue, completed at the beginning of Term One and revised throughout the curriculum, with the aim to develop a transculturally safe and challenging learning environment
• distant and international health fieldwork opportunities that expose students to role merging practice areas or underserviced populations with follow-up reflective sessions
• use of role-playing, guided imagery, simulated patients and patient partners to engage students in learning about the perspectives of others
• experiential skills labs (e.g., wheelchair mobility lab)
• students’ immersion in research where problems are analyzed from different theoretical and methodological stances

Assessments in our curriculum derived from Transformative Learning Theory include:
• the use of reflective papers and portfolios completed within the mentorship course where mentors facilitate an emerging awareness of a professional identity among their mentees
• assignments focused on occupational therapists as change agents, which challenge students to consider their role in bringing about social or organizational change that goes beyond the individual client (e.g. OT Practice 1 policy and OT Practice 3 entrepreneur assignments)
• group projects in which students develop creative solutions to common occupational issues (e.g., technology design project, older adult social issues response seminar)
While Mezirow’s (1991) transformative learning theory is foundational to our curriculum, we also draw on other theories to guide our curriculum. In the educational literature, a common way to think about the relationship among the various learning theories is by using an historical frame that demonstrates how the various theories have developed over time. For example, early behaviourist theorists such as Pavlov and Skinner emphasized skill building through systems of rewards and feedback, which then informed cognitivist theorists, for example, Bandura, who sought to explain the internal cognitive learning processes (Snowman, McCown & Biehler, 2012). These theories are based on a more objectivist stance and have lost some prominence with the emergence of constructivist approaches. Constructivist approaches take a subjectivist stance to examine how learning, while constructed internally using cognitive schemas, is negotiated within diverse sociocultural perspectives on what is accepted as reality. According to Mergel (1989), behaviorism and cognitivism are both concerned with breaking down learning tasks and identifying clearly measurable, behavioural objectives. Behaviourist approaches are evident in reinforcing students’ contributions during class, tests, receiving grades, and positive verbal feedback. Skill-based learning may benefit from a behaviourist approach (e.g. repetition of neuro-rehab techniques) that is reinforced by the practice partner, client, or supervising therapist. Cognitive approaches inform the breaking down of tasks and teaching from simple to more complex tasks. Constructivism fosters more divergent thinking and acknowledges that students may experience diffuse and lateral learning outcomes that are not easily quantified and measured.

**SOCIAL CONSTRUCTIVISM**

*Brief Overview:*
Social constructivism is based on specific premises about reality, knowledge and learning: reality is invented or constructed through human activity, and knowledge is developed through the interactions of people with each other and the environments that surround them. Learning, therefore, is seen as a social process. Merriam and Caffarella (1999) distinguish between constructivism as a process of creating the meaning of experience, and social constructivism which views meaning-making as a process shaped by social interaction and discourse. Social constructivism leads to a greater focus on self-directed learning. Social constructivism challenges the notion of the learner as a passive recipient of transmitted knowledge and assumes that learners construct knowledge based on internal cognitive processes, social interactions and other experiences. The interaction of the student group and their environment in the creation of knowledge is critical, and, therefore, considerations of culture and context are fundamental in the learning process.

It follows that instructional models based in this perspective will emphasize collaboration among learners within the environments that are important to them. Educational approaches from this

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3 Though social constructivism and constructionism are often used interchangeably and while they both speak to the active involvement of learners in “constructing” knowledge the former has its basis in cognitive psychology and emphasizes cognitive processes while the later emphasizes that learning is constructed based on external social processes. "The word with the v expresses the theory that knowledge is built by the learner, not supplied by the teacher. The word with the n expresses the further idea that happens especially felicitously when the learner is engaged in the construction of something external or at least sharable" (Papert & Harel, 1991, p.3).
perspective focus on methods that involve learning with others, including reciprocal teaching, peer collaboration, cognitive apprenticeships, and problem-based instruction (Schunk, 2000).

**An educator in the classroom or in fieldwork who uses Social Constructivism will:**

- appreciate that learners bring prior academic knowledge and social and cultural experiences to the learning environment
- require students to consider the social, physical and policy contexts when seeking possible solutions to individual and social problems
- facilitate a process of critical questioning to build shared understandings
- challenge the notion that there is one solution to each problem

**Specific examples of Social Constructivism in our curriculum include:**

- case-based discussions where students examine their own understanding of the problems and their contexts, and collaboratively (with student peers, instructors and where possible, clients, families and other informed members of the public) construct potential solutions
- collaborative project development within study and mentor groups leading to papers and seminar presentations
- fieldwork placements where learning is constructed within particular practice contexts
- student portfolios, which offer students an opportunity to construct their professional self through self-reflection and dialogue
- interprofessional educational opportunities where students learn about the profession and practice of occupational therapy and other health disciplines within the context of an interprofessional team

**Assessments derived from Social Constructivism:**

- emphasize the need for clinical rationales, including contextual analyses of case-based class discussions, written assignments, and examinations
- use group assignments where students build their conceptual knowledge through shared creative problem-solving
- prompt students to identify assumptions that may or may not be shared by others in both class discussions and in fieldwork

**CRITICAL PEDAGOGY**

**Brief Overview:**
Closely linked to transformative learning theory is critical pedagogy. Critical pedagogy is a philosophy of education that endorses and nurtures students’ critical thinking (Giroux, 2010; Shor, 1996). Critical pedagogies promote students’ learning through cycles of theory, application, evaluation and reflection. Students and teachers engage in questioning ‘taken-for-granted’ assumptions by unmasking and challenging power inequities and social injustices, and resisting the reproduction of social constraints and hierarchies. Students and teachers value alternate ways of knowing and acknowledge the perspectives of marginalized or under-represented people alongside
more dominant, authoritative scientific knowledge. The goal of critical pedagogy is social transformation. We view the adoption of a critical pedagogical approach as key to the education of future occupational therapists, who will individually and collaboratively advocate and mediate positive social change. Though closely linked to transformative learning, critical pedagogy more explicitly identifies and problematizes the social and power inequities in everyday interactions that shape the lives of the people served by occupational therapists.  

**An educator in the classroom or in fieldwork who uses Critical Pedagogy will:**

- require students to critically examine implicit assumptions, power imbalances, inequities and the social structures that maintain these
- facilitate students’ identification of how social locations may further marginalize the people they aim to serve, for example, in their roles as gatekeepers to government funding for assistive devices, occupational therapists may reinforce inequitable social policies
- acknowledge that there are dominant worldviews which maintain concentrations of power and privilege through existing social structures and language
- clarify that society is not always just, and since the mechanisms that sustain power inequities may be invisible to those who are marginalized, an ongoing struggle for equity is required

**Specific examples of the influence of Critical Pedagogy in our curriculum include:**

- the anti-oppression frameworks workshop held in the mental health foundations course where students are led through exercises that help them to identify their own fluctuating positions of power, privilege and oppression
- student engagement in identifying and challenging professional dominance during clinical problem-solving e.g., the weighting of client self-knowledge versus scientifically derived norms in decision-making in classroom cases and in fieldwork
- educator use of narratives of exemplar change agent strategies used by occupational therapists and others to affect change beyond the individual level
- educator modeling of responsible critical analysis of power structures such as language, economic institutions and social practices that affect one’s occupational engagement

**Assessments derived from Critical Pedagogy:**

- ask how students’ understanding of power structures and mechanisms has affected their knowledge of the practice of occupational therapy
- evaluate students’ knowledge of critical theory concepts, for example, social structures, social location, and disability activism

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4 Because of their similarities, critical pedagogy influences in the curriculum also are reflected in some of the strategies outlined in the section on transformative learning.
**KOLB’S THEORY OF EXPERIENTIAL LEARNING**

**Brief Overview:**

Experiential learning can be understood as a “direct encounter with the phenomena being studied rather than merely thinking about the encounter, or only considering the possibility of doing something about it” (Borzak 1981:9). Although there are a number of theorists whose work is based on experiential learning, Kolb’s theory of experiential learning (1984) is the most widely known and cited. Kolb focuses on understanding the processes required to make sense of concrete experiences and the associated styles of learning.

Figure 1 shows that experiential learning theory is based on four key elements: (1) concrete experience, (2) observation and reflection, (3) the formation of abstract concepts, and (4) testing in new situations (Kolb, 1984). While Kolb hypothesized that his learning cycle can be entered at any point, he suggested the optimal point of entry is the concrete experience that forms the base for reflection.

Through the cycle of doing and observing the consequences, the learner analyzes patterns and hypothesizes general principles (abstract conceptualizations), and then tests these in context (active experimentation). Kolb’s theory is particularly useful in guiding educators on how and when to introduce theory in the learning cycle. Kolb (1984) believed that individuals are stronger in some aspects of learning than others, and posits the four types of learners that are described in Table 1.

**Table 1: Kolb’s Types and Characteristics of Learners**

<table>
<thead>
<tr>
<th>Learning Style &amp; Characteristics</th>
<th>Description</th>
</tr>
</thead>
</table>
| Convergence: Abstract conceptualizations and active experimentation | • strong in practical applications of ideas  
• can focus on hypo-deductive reasoning on specific problems  
• can be unemotional, has narrow interests |

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**An educator in the classroom or in fieldwork who uses Kolb’s Cycle of Experiential Learning approach will:**

- explicitly ask students to reflect, conceptualize, and experiment with new experiences, ideas and skills
- continually add new variables or contingencies into case discussions to assist students in their efforts to generalize or theorize new ideas

**Specific examples of the influence of Kolb’s Cycle of Experiential Learning in our curriculum include:**

- case-based learning
- modeling by lab facilitators to promote students’ reflections and conceptualizations while on employing, for example, adult learning principles during ADL training tasks to enable clients’ desired skills
- fieldwork (inherently an experiential activity)
- mentorship groups offering students opportunities to experience and receive feedback on essential therapeutic skills such as giving and receiving feedback, group facilitation and mediation
- reflecting on students’ fieldwork experiences in the classroom and theorizing applications to future placements and contexts of practice
- using various forms of simulation where students have the opportunity to practice competencies

**Assessments derived from Kolb’s Cycle of Experiential Learning will:**

- use observation of skill development to evaluate student performance
- use simulated clients to assess student performance
- ask students to generalize newly acquired knowledge to novel and variable situations
COGNITIVE NEUROSCIENCE THEORY............................................................................................................................

Brief Overview:
Cognitive learning theories emerged in the 1920’s in response to behaviourism, which according to early critics was not able to explain all learning (Mergel, 1998). There is evidence that the learning process occurs within the networks and neurons of the brain and that learning process makes permanent changes in the neural architecture of the brain. Discoveries about learning from the cognitive neuroscience field have critical implications for the educational process.

Memory: The manner in which learners attend to, encode, organize, transform, rehearse, store and retrieve information is understood to be critical for learning (Ertmer & Newby, 1993):

1. Memory has several components and systems (Squire & Zola Morgan, 1998), as depicted in Figure 2 below.
2. Memory formation and retrieval involve encoding, storage or retention, and retrieval (free recall, cued recall, recognition).
3. How information is encoded affects retention (e.g. verbal vs. visual; shallow vs. deep processing).
4. Prior learning can interfere with new learning.
5. Our brains learn and process both non-conscious, automated knowledge (implicit memory) and conscious, controllable knowledge (explicit).
6. Working memory, that is, manipulating information while holding it ‘on-line’, has a very limited capacity and duration.

Cognitive Load Theory (CLT): Cognitive load theory is derived from the neuroscience of memory, particularly the limited capacity of working memory and the unlimited capacity of long-term memory. CLT asserts that learning by being asked to construct or discover how to solve problems or perform complex tasks overloads working memory and inhibits learning for students who have basic to intermediate levels of relevant prior knowledge (Clark & Clark, 2010). Van Merrienboer & Sweller (2009) have recently described how CLT should inform instructional design in medical education, noting that working memory load is affected by the intrinsic nature of the learning task (intrinsic load) and by the manner in which the tasks are presented (extraneous load). Thus, one approach to enhancing learning may be through reducing the extraneous load by, for example, replacing conventional problem solving tasks with worked examples which have full solutions that students can critique. Another way to manage the intrinsic load by is by building examples or cases from simple to complex.
**Figure 2: Components of Memory** (Squire & Zola-Morgan, 1998)

![Figure 2: Components of Memory](image)

**An educator in the classroom or in fieldwork who uses Cognitive Neuroscience Theory will:**
- reduce the working memory load associated with having to mentally integrate several sources of information by physically integrating those sources of information
- increase working memory capacity by using auditory as well as visual information under conditions where both sources of information are essential (i.e., non-redundant) to understanding
- introduce experiences to allow students to encode information more deeply, e.g., read what is written on slides, encourage students to take notes
- provide students with worked examples of, e.g., treatment plans for them to critique prior to expecting them to develop a treatment plan (Sweller, 1988)

**Specific examples of the influence of Cognitive Neuroscience Theory in our curriculum include:**
- the use of reflection to deepen encoding and to link present learning to past experiences in order to maximize learning opportunities
- consistent use of complementing audio with visual materials

**Assessments derived from Cognitive Neuroscience Theory will:**
- be graded from simple to more complex to match development of students’ knowledge, attitudes and skills across the curriculum
- consider the amount of information included in each question to prevent overtaxing working memory systems in an exam situation

**BLOOM’S TAXONOMY OF LEARNING**

**Brief Overview:**
Bloom’s taxonomy of learning (Bloom et al., 1956) is not a theory that explains how people learn, but rather a comprehensive categorization of the developmental aspects of knowledge types and
learning processes. It is a foundational tool in the MScOT curriculum and is used by our faculty to move from theory to practice. Bloom’s taxonomy of learning was developed in the 1950s, and it has been used widely since to develop educational goals and objectives. The original taxonomy and the revised version by Anderson and Krathwohl (2001) are shown in Figure 3.

Figure 3: Bloom’s Taxonomy: Original & Revised Versions

In addition to changing the nouns to verbs, Anderson and Krathwohl’s (2001) revised version also incorporates different types of knowledge (factual, conceptual, procedural, meta-cognitive) at each level of learning. Heer (2009) has designed an interactive model of learning objectives that highlights the intersection between the ‘knowledge’ dimension and the original ‘cognitive-process’ dimension and provides examples of learning objective verbs at each level. For example, the verb ‘list’ is at the intersection of ‘factual knowledge’ on the knowledge dimension and ‘remember’ on the cognitive dimension, while the verb ‘create’ is at the intersection of ‘meta-cognitive’ on the knowledge dimension and ‘create’ on the cognitive-process dimension.

Later developments have incorporated affective and psychomotor domains, thereby providing a more holistic approach to education (Figure 4). The affective domain is used to characterize student values and attitudes and includes: (1) Receiving: being aware or conscious of an event; (2) Responding: reacting to an event; (3) Valuing: internalizing a belief; (4) Organization: commitment to a set of values; and (5) Characterization: a change in character or an internalization of a revised value system. The psychomotor domain is concerned primarily with motor skill development necessary for complex motor or technical tasks and includes: imitation, manipulation, precision, articulation and finally, naturalization.

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6 Figure 3 is adapted from R. C. Overbaugh and L. Schulz’s “Bloom’s Taxonomy” (2009). Retrieved June 27th 2012 from [http://www.medschool.vcu.edu/graduate/pgmdir_res/documents/bloomtaxonomy.pdf](http://www.medschool.vcu.edu/graduate/pgmdir_res/documents/bloomtaxonomy.pdf)
Figure 4: Atherton’s (2011) Versions of Bloom’s Taxonomy: Affective & Psycho-Motor Domains

Bloom’s taxonomy’s influences in the MScOT curriculum:
The use of Bloom’s taxonomy is reflected in the developmental flow of our curriculum and courses as outlined here:

<table>
<thead>
<tr>
<th>Basic</th>
<th>Complex</th>
</tr>
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<tbody>
<tr>
<td>Generic</td>
<td>Specific</td>
</tr>
<tr>
<td>Teacher-directed</td>
<td>Student-directed</td>
</tr>
<tr>
<td>Novice</td>
<td>Expert</td>
</tr>
<tr>
<td>Foundation</td>
<td>Occupational Enablement</td>
</tr>
</tbody>
</table>

Specific examples of the influence of Bloom’s Taxonomy in our curriculum include:

- using the categories and key words of the domains in writing learning objectives for classes and courses
- planning and evaluating how a class, an assessment process or a course incorporates a range of cognitive, affective, and psychomotor learning objectives and competencies
- planning and evaluating whether courses, terms and the program move students’ learning from simpler to more complex concepts and reasoning, behaviours and professional behaviours
- provide a “just right challenge” in learning tasks and environments
- the developmental flow of the divergent case method process (Cockburn & Polatajko, 2004)

Assessment derived from Bloom’s Taxonomy will:

- use various levels of the cognitive domain of Bloom’s taxonomy to develop assessment tools and test questions by identifying behaviours associated with increasing levels of complexity (Figure 5)
Summary:

The University of Toronto MScOT Educational Conceptual Framework, 2012 describes the concepts, constructs, principles, values, beliefs, and theories that inform our overall approach to teaching, learning, and curriculum development and renewal. This document is intended for use by faculty and students to explicitly identify the theoretical assumptions that influence both teaching and learning. Faculty members draw upon specific educational theories and taxonomies to address particular learning objectives for building students’ competencies in knowledge, skills and professionalism for entry to occupational therapy practice. Social constructivism, critical pedagogy, Kolb’s theory of experiential learning and cognitive neuroscience theory are utilized within the overall principles of transformational learning theory.

Diverse educational theories within the curriculum allow the program to accommodate students’ varied learning styles. Our educational conceptual framework explicitly acknowledges the diversity of individuals’ learning needs and the breadth of the practice of occupational therapy, and provides a resource for the evolution of curricular content and educational processes. Our educational conceptual framework is dynamic and will evolve with emerging educational scholarship, changes in professional practices, feedback from students and graduates, faculty members’ continuous reflection on their educational practices, and ongoing course and curriculum evaluation.

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Figure 5: Alcorn’s Bloom’s Revised Taxonomy for Assessment

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REFERENCES


