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Abstract

Clinical supervision is critical for preparing podiatry students for clinical practice. However, little is known about clinical supervisors' preparedness to supervise podiatry students in clinical practice. This exploratory qualitative study explored clinical supervisors' perceptions of their preparedness to supervise podiatry students in Australia, in terms of their training, challenges and suggestions for improving supervision quality. Semi-structured interviews with 11 clinical supervisors (6 females, 5 males) were audio-recorded, transcribed and thematically analysed. Watkins' (1990) four-stage model characterising supervisor development was used to inform analysis. Generally, clinical supervisors did not feel adequately prepared for their supervisory role, largely because of a lack of formal training. Challenges included the time burden of supervision, inconsistency regarding competence assessment standards, and student-related issues such as a perceived lack of interest. Recommendations for improving clinical supervision included a greater understanding of students' learning needs and more training opportunities. Clinical supervisors were of the opinion that partnering universities were largely responsible for ensuring quality supervision practices. As clinical supervisors generally felt unprepared to supervise, this impacted on their self-efficacy. Greater role clarity, training and support is thus needed to ensure clinical supervisors are adequately prepared for the role and to facilitate progression through supervisory developmental stages.

I INTRODUCTION

Clinical placements in authentic supported learning settings (Birks et al., 2017; Connor, 2016; Manninen, 2016), provide opportunities for students to practice the skills required to graduate as competent podiatrists (Australian and New Zealand Podiatry Accreditation Council [ANZPAC], 2015a). Without clinical placements, it would be difficult for pre-registration podiatrists to develop the required hands-on training with patients and to integrate theory into practice (Australian and New Zealand Podiatry Accreditation Council [ANZPAC], 2015b; Levy et al., 2009) to maximise their clinical learning (Domakin, 2014; Wrenn & Wrenn, 2009). Clinical placement is therefore acknowledged as a fundamental component of podiatry training (Baraz et al., 2015; Lamont et al., 2015), experiential learning (Kolb, 1984), and is critical for ensuring clinical competence (ANZPAC, 2015a; Rodger et al., 2008). Australian podiatry students must complete a minimum of 1,000 hours in appropriate clinical training facilities, e.g. internal (connected with the university) or external (public and private) clinics during their degree (ANZPAC, 2015b). Most undertake their first organised clinical placement in their second year of study (Causby et al., 2017).

Clinical supervisors, who are registered podiatrists, are responsible for supervising podiatry students during clinical placements. A low student-to-supervisor ratio ensures patient and student safety during this training (ANZPAC, 2015b; Kilminster & Jolly, 2000). Clinical supervisors must, however, simultaneously manage patient care and supervise and assess students (Carlson & Bengtsson, 2015; Manninen et al., 2015), whilst fostering a positive learning environment (Bannister et al., 2015; Brown et al., 2013). Clinical supervisors should, therefore, be skilled clinical practitioners as well as proficient trainers and educators. But being a good clinician does not automatically translate into being a good supervisor (Carlson & Bengtsson, 2015; Higgs & McAllister, 2007; Razmjou et al., 2015; Rodger et al., 2008). Similarly ‘on-the-job’ experience (Kolb, 1984) should not replace any need for preparatory supervisor training (Kilminster & Jolly, 2000). Undertaking training in clinical supervision is known to build supervision skills (Martin et al., 2014) related to, for example, understanding the concept and purposes of supervision, assessment, feedback, counselling skills and appraisal (Kilminster & Jolly, 2000). Understandably then, the quality of clinical training and support provided by clinical supervisors can significantly influence learning (Baraz et al., 2015; Levy et al., 2009). The supervision process must be appropriate for the student’s level of experience and training (Levy et al., 2009) and be constructively aligned with the curriculum to ensure students are prepared for professional practice (Walsh, 2007). As the supervisory skills and approach of clinical supervisors (e.g. their capacity to engage in clinical education) is a key factor in placement success (Abey et al., 2015; Bengtsson & Carlson, 2015; Bos et al., 2015), clinical supervisors should be adequately prepared for their educational role (Dehghani et al., 2016). Despite the importance of clinical supervision in students’ professional development, research is lacking in terms of clinical supervisor preparedness to supervise podiatry students and barriers and opportunities for supervisor professional development. This phenomenological study thus sought to understand i) the perceived preparedness of podiatry clinical supervisors to supervise pre-registration podiatry students, ii) training received by podiatry clinical supervisors, iii) their challenges as supervisors, and iv) their recommendations for improving supervision quality.

A *Theoretical considerations*

Watkins’ (1990) model of the psychotherapy supervisor, adapted from Wiley and Ray (1986) has been used in this study as it provides a developmental approach to the different stages (role shock, recovery and transition, role consolidation, and role mastery) that can be expected in becoming and then being a supervisor. This model encompasses issues related to confidence in supervisory skill, impact on supervisees, approach to a theoretical framework and a sense of professional identity (Table 1). In addition, this model considers the role of training in terms of how to be a supervisor and the supervision of novice supervisors by more experienced ones. Thus, the described experiences herein related to supervision, including the influence of past training and the challenges of being a supervisor, were used to evaluate supervisors’ preparedness and their related professional development.

Table 1.
Summary of Watkins' (1990) adapted model (Wiley and Ray, 1986) of the various stages of development of psychotherapy supervisors.

Psychotherapy Supervisor Stages

Developmental issues	Role shock	Role recovery/transition	Role consolidation	Role mastery
Confidence in current supervisory skill	Acutely aware of weaknesses, questions abilities, lack confidence, feel overwhelmed and unprepared	Recognises some strengths and abilities, confidence develops in restricted areas, less generalised questioning of oneself, can still easily be shaken when confronted with supervisory problems	More realistic, accurate perceptions of self and supervisees, general, firm sense of confidence in one's abilities and skills, not easily shaken when confronted with supervisory problems	Consistent, solid sense of confidence in abilities and skills, handles supervision problems effectively and appropriately
Insight about impact on supervisees	Has very limited awareness about supervisory strengths, style and motivations, and their impact on supervisees	Developing awareness of impact on supervisees, favourable impression about impact still overshadowed by unfavourable impressions	More consistent awareness of supervisory strengths, weaknesses, style and motivations and their impact on supervisees, favourable impressions about impact become predominant	Consistent awareness about supervisory strengths, weaknesses, and their impact of oneself as effective supervisor firmly established
Approach to a theoretical framework	Little if any awareness about one's own supervisory style or supervisory theory	Limited recognition of certain behaviours, ideas, and tenets that characterise one's practice of supervision, beginning reflection about a personal theory of supervision	More consistent recognition and definition of aspects that characterise one's supervisory style, a personal theory of supervision takes more solid form	Coherent, well-integrated, theoretically consistent supervisory style is evidenced, theory of supervision highly meaningful, personalised, and consistently guides practice
Sense of professional identity	No real sense of professional identity, no real identification with the supervisory role, looks to others for help and guidance	Crude, nascent identity core starts to take form, but is fragile and unconsolidated, less intense reliance on help and guidance of others	Considers self a "supervisor", identity core established, leans on others at difficult times, but has sufficient inner resources for self-sustenance	Well-integrated, consolidated, well-elaborated sense of identity, views self as professionally effective, facilitative supervisor, is self-reliant

II METHODS

Following approval by the Bond University Human Research Ethics Committee (RO15226), past and current clinical supervisors in Australia were purposively recruited and interviewed (semi-structured) to glean their perspectives. For the purpose of this study, the clinical environment included public and/or private practice, community health service and clinics at universities. Advertisements were placed with the Australasian Podiatry Council between October 2015 and May 2016. Although 17 Australian registered podiatrists were initially recruited, only 11 were interviewed as six withdrew due to other commitments. Participants were aged between 29 and 57 and had been supervising on average for 8.6 years (Table 2).

Table 2.
Demographic profile of participants

Participant (ID)	Age	Number of years since graduation	Country of graduation as a podiatrist	Years of clinical supervision	Year level of supervision	Working Sector
P1M	40	9	Australia	9	4	Private
P2M	29	7	New Zealand	3	4	Private
P3F	41	20	Australia	17	4	Public
P4M	40	19	Australia	8	2,3,4	Private
P5F	29	6	Australia	1.5	3	Private
P6M	37	8	Australia	1	3,4	Private
P7M	42	19	Australia	18	2,3,4	Private
P8F	52	32	Australia	15	3,4	Private
P9F	57	35	Australia	10	4	Private
P10F	44	23	Australia	6	3,4	Public
P11F	29	8	Australia	6	4	Public
	40 ± 9.0	**16.9 ± 10.2**		**8.6 ± 5.9**		**8 Private; 3 Public**

Note. N = 11. P = participant. M = male. F = female.

An interview guide comprising six questions was designed and piloted with one clinical supervisor who was then not included in the study. The questions were based on a literature review and framed to support the overarching research question relating to clinical supervisor preparedness to supervise. Pilot testing the interview questions allowed the primary researcher, as principal investigator (PI), to gain a good sense of the guide and to enable minor refinement of wording for clarity prior to use (DeJonckheere & Vaughn, 2019) (Appendix 1). Due to the national location of the clinical supervisors, one-on-one interviews were conducted via telephone by the PI, in a private space, at a time convenient for participants (DiCicco-Bloom & Crabtree, 2006). Written consent was completed and returned via email prior to each telephonic interview. From the explanatory statement, participants understood that the PI was a registered podiatrist, that the study was part of her PhD degree intended to inform preparation of clinical supervisors involved in pre-registration curricula, participation was voluntary and that they could withdraw at any time or refuse to answer any question without penalty. Most interviews lasted 20-30 minutes. Notes were taken to supplement audio-recordings which were professionally transcribed and then checked against the original audio files to ensure accuracy. Participants were de-identified.

As this was an exploratory study, thematic analysis was used (Braun & Clarke, 2006). The transcripts were read and re-read while listening to the audio files (Burgess-Allen & Owen-Smith, 2010). As the PI is a registered podiatrist and had been a clinical supervisor, so as not to influence interpretation, awareness of any pre-conceptions was maintained throughout the analysis through a continuous reflective process. Both researchers read the narratives several times to familiarise themselves with the data. Initial codes were generated and grouped into categories according to

their similarities. With 11 sets of data, this was done manually by working through hard copies of transcripts with pens and highlighters. Categories were grouped/consolidated into themes. The themes were then reviewed and discussed to reach consensus. The researchers considered saturation of themes was reached by the tenth interview. The different perspectives (i.e. second researcher, a medical educator with PhD and not a podiatrist) enabled robust interrogation of data. Next, the themes were examined and related quotations identified for final analysis of suitability for this paper (Braun & Clarke, 2006). However, member checking was not carried out as the researchers acknowledged that new experiences (by the participants since interview) could potentially influence the analysis (Creswell, 2013).

III FINDINGS

The findings are reported in terms of the four areas this study set out to explore, i.e., i) perceived preparedness of podiatry clinical supervisors to supervise pre-registration podiatry students, ii) training received, iii) challenges they faced as supervisors, and iv) their recommendations to improve supervision quality.

A *Unprepared to supervise*

Despite the combined average years (8.6 $\pm$ 5.9) of clinical supervisory experience, the majority of clinical supervisors (n = 8) felt either unprepared or poorly prepared for their role as clinical supervisors. Some acknowledged that the role of clinical supervisor required a different set of knowledge and skills from that of a podiatrist:

> "I am going to say probably not all that prepared...Teaching and podiatry are not the same thing...I think if you are a good podiatrist, it doesn't necessarily make you a good supervisor." (P1M)

> "Not necessarily that well. There's a difference between being a good podiatrist and being a good supervisor slash teacher. They are different skill sets." (P2M)

> "Not very well prepared, yep, like 5 out of 10. There's quite a difference to being a teacher rather than just a clinician." (P4M)

For the two clinical supervisors with the least experience (12 and 18 months, respectively), becoming a supervisor involved very little or no attention to professional development as a clinical supervisor:

> "I got thrown into the role with essentially no training. I just got given the manual and read it and then went straight in. Eighteen months on, I feel like I am getting the hang of it, but it has certainly been a big learning curve for me...I am not an academic and...I have found it difficult, so I don't think I've been really ready." (P5F)

> "On the balance of things, probably not good at all…not prepared." (P6M)

The same lack of preparedness was also the case for the two longest serving clinical supervisors (17 and 18 years in the role), each using the third person to express their viewpoints as a generalisation of current supervisors: "…the majority are poorly prepared" (P3F); "extremely unprepared, zero" (P7M). In addition, this latter supervisor identified a lack of role clarity, related to overall scope and responsibilities of their job as supervisor, despite many years in the role:

> "I sort of feel like I really don't know what's expected of me as a supervisor…I don't think the University can plan to offer external clinical placement as part of the student's degree without providing some guidance in training through the external supervisors." (P7M)

Only three clinical supervisors felt prepared to supervise, two of whom had undertaken post-graduate studies which included subjects specific to facilitating education in clinical practice settings. Common to these few, however, was a communicated confidence in their professional clinical skill experience and preparedness to supervise:

> "I think it is important that the students get exposed to high levels of excellence… Supervisors should be of a certain calibre and the profession ought to acknowledge that they are at that calibre." (P8F)

"I think it depends on the experience that we've had. I think it really comes down to the experience of the clinician…so we feel quite knowledgeable…I think that actually helps when you feel like you know your stuff quite well." (P10F)

B *Lack of initial supervisor training and ongoing professional development impacting preparedness*

When asked what training or educational support had been received from the university or health service to assist them in their role as clinical supervisors, their responses ranged from none, to receiving documentation, to one-day workshops at best (Table 3). Those who discussed receiving no supervision training or related professional development support also felt that they were not prepared for their supervisory roles. Despite all of them supervising university students, the university had provided little or no training or support. The support from the university was generally restricted to documentation, i.e. either a handbook or manual regarding assessment guidelines and checklists and dress code. Few reported workplace training sessions relating to administrative processes to manage clinical placement allocations, or targeted supervisory training workshops on, for example, managing challenging student behaviours, which they had found useful.

Table 3.
Past support or training received for their role as clinical supervisors

Training/support	Associated responses
Documentation from the university	"Okay, the answer is yes, until you said from the university ...they just gave us a book to read." (P1M)
	"You get sent out a bunch of different bits of paper saying what's an effective supervisor ...you get examples of the criteria that the students are going to be assessed on." (P4M)
	"Just a manual which really only talks about things like the uniform that the students should be wearing and the schedule. There's not much in terms of offering feedback or the things that require a bit more work than just the uniforms or punctuality and things like that." (P5F)
	"We get the handbooks and I glance through that...nothing really official, no formal education." (P8F)
Supervisor sessions	"Yes, I have had training through the Department of Health, not through the university...about having difficult conversations with students, how to best raise concerns…it's really just one day workshops ..." (P2M)
	"The university had something every year that might have been for two hours. It was very, very little from the university and it was more in the way of here's how to fill in the forms on how to mark them. I was part of a clinical education school, so I was really, really well supported by my peers ...we had a lot of teaching on how to give feedback, how to teach a manual skill, how to facilitate peer-to-peer learning." (P3F)
	"I'd say from the health service, nothing, other than we got trained because all our students come via ClinConnect now. It was more of a process. From the university, I've been to …, two ...I have been to a clinical education session and it was titled 'Managing student behaviours' but that was run by the University of Sydney (which doesn't teach podiatry) and one at the University of Western Sydney." (P10F)
	"In our health district, we have to do clinical supervision. The universities occasionally run maybe once every few years a seminar on connecting with students." (P11F)
Nil	"None (laughing)." (P6M)
	"That's a good question. I could probably honestly say absolutely nothing. Certainly nothing formal." (P7M)
	"I think there were some early on, but it was 9-5 with not a lot of notice, so I wasn't able to go. Basically, I would say, none." (P9F)

When asked about who was responsible for improving the quality of clinical supervision, participants were unanimous that universities were primarily responsible for ensuring the quality of supervision of their students and for offering supervisor development training, with five of the 11 also acknowledging their personal responsibility:

> "I think its 50/50 in the sense I should probably do some reading and maybe take some short courses and maybe look at the ways I can improve my ability to supervise. Then I think it's also the university's responsibility in some way to make these sorts of courses available to supervisors or provide updated material." (P5F)

> "I think it is my personal responsibility to be up-to-date, good and on the ball, but I think the University also ought to know I am." (P8F)

And four of the 11, the organisation (placement site) accepting the placement:

> "It's a combination of the university and also the organisation that agrees to take students." (P2M)

C *Challenges faced as supervisors*

Three sub-themes were identified in terms of clinical supervisor challenges: *Burden of supervision*, *lack of consistency in terms of acceptable standards* and *student-related issues* (Table 4).

Table 4.
Challenges identified by clinical supervisors

Theme	Other associated quotations
Burden of supervision	"It's hard to spend enough time ...you might need to speed it up because otherwise you're not going to have your lunch hour...or you are going to be running late for 2 hours." (P4M)
	"Being able to keep to time so it is financially viable for my business because I like to spend time with my students and teach them things." (P6M)
	"I really like taking students …but then trying to encourage my colleagues to feel the same, can be quite challenging as well." (P11F)
Lack of consistency in terms of acceptable standards (e.g. competence assessment)	"Absolutely frustrated when you've got a student in front of you that you know should never be a podiatrist, ever. Having really poor back-up from the university pushing that student through …We don't have consistency in marking. What I see as competent, you might not see as competent ...I think there is a lot of challenges with that in particular." (P3F)
	"I guess with how subjective our role is, so sometimes I'll suggest something to a student on maybe how they could improve and then they come back and say to me, "Well the other supervisor said this was okay to do it this way." Then I feel like I am justifying the way I do it. Whilst we are all giving the same evidence-based message, we all have our different slant on it." (P5F)
	"Probably the things that spring to mind are a lack of consistency from the University and/or student. Yeah, lack of consistency between students …Lack of clarity from the University about the way the student performs and the sorts of things that should be done, which I suppose might get back to the lack of training ..." (P7M)
Student-related issues	"Also dealing with different personalities as well ...which is professional behaviour with students." (P2M)
	"The students are frequently at the placement because they have to be at placement. The attitude ...they can often be quite insecure in some areas and then quite arrogant in other areas." (P9F)
	"There was a time there when it felt like this student's priority was more just getting things ticked off ...I think you find that towards the end of the year, maybe once they have done a lot of placements...Because of that reason, we have opened up more of the beginning of the year because we find students a little bit more enthusiastic." (P11F)

1 *Burden of supervision*

This related mainly to time commitment. Being an effective clinical educator requires good time management, leaving little time for professional development as an educator:

> "It's hard for the podiatrist to actually find the time to set aside to be educated [as a clinical supervisor]." (P4M)

Others identified how being a clinical supervisor takes time away from clinical practice, leading to role conflict:

> "The constant onslaught of students! Yep, I feel like I spend most of my time supervising students and not my actual podiatrists that I manage. That is a challenge." (P2M)

> "You do it out of the goodness of your heart because you don't get anything and its very challenging. It is very time consuming to have a student in private practice for a week." (P9F)

Some described the financial implications of being a clinical supervisor:

> "I have spent a day supervising and I would wind up being $20 worse off than if I hadn't been there at all…If you have a mortgage or a family or a practice to run you can't afford to teach." (P1M)

> "We do take on that role, but we don't get any financial reward for it or we don't get any recognition for it except we feel like we've done our part." (P10F)

It was not surprising that then *personal burnout* was identified as a challenge when dealing with patients and students:

> "I think it's just fairly exhausting…we are working a lot of patients on the ground…and it is actually quite a tiring job to do." (P8F)

Interestingly, one supervisor also identified patient fatigue from constantly having students attend to them on placement:

> "We probably get a bit of patient fatigue with students...so, a few of our patients will be like 'Oh, it's nice just to sit here with you. The students are lovely but it's nice that they are not here every day." (P10F)

2 *Lack of consistency in terms of acceptable standards*

Most clinical supervisors recognised a need with regard to supervisor assessment practices, including their use of feedback, both formative and summative, and a desire to minimise any subjectivity of judgement, for example, when multiple supervisors are assessing a student (Table 4):

> "We can't have students actually being marked by people [clinical supervisors] that aren't trained. When you don't have standards against how we are marking…we don't have consistency in marking. What I see as competent, you might not see as competent." (P3F)

> "There doesn't tend to be the consistency that is needed in clinical supervision…I just think you have to assess them objectively and I think sometimes they get marked down for silly things without justification for it. I think there needs to be a more robust assessment system in place to make it more consistent." (P10F)

3 *Student-related issues*

This related to dealing with different personalities, confidence issues and, at times, student lack of engagement in the placement process. For example, some students spend "half the time basically marking the clock" due to their disinterest in some components of clinical practice "...like nail-cutting or corns because most of the students think they are going to be doing high-end biomechanics research stuff". (P9F)

> "Not always are the students engaged in being on their placement. And they are not that interested in it. So that can be one of the challenges." (P2M)

D *Recommendations for improving supervision quality*

When asked about what would be helpful to their supervisory roles, it was not surprising that supervisors identified the need for a *better awareness of student learning needs* and the provision of *clinical supervision training opportunities* (Table 5). In terms of *student learning needs,* explicably, they required information about the content students had covered prior to their placement as well as detailed information about the students' intended learning outcomes for the placement. Also identified was knowing which students required additional supervision as a consequence of having experienced students with difficulties on placement and wanting to better accommodate their individual learning needs.

Requests for *specific clinical supervision training opportunities* predominantly from the partner university (as a learning continuum approach) included guidance on how to provide effective feedback, different educational approaches for clinical supervision, strategies to manage the poor performing student and self- and peer-assessment techniques (Table 5). These would allow clinical supervisors to be realistic judges of their own performance as well as being confident that their supervision was effective. Suggested formats for training facilitation comprised case scenarios involving practical examples in clinical supervision, and/or days held at the university for clinical supervisors to gain greater insight into how students learn and how they are assessed in the university-based clinical setting to ensure consistency amongst clinical supervisors during students' external placements.

Table 5.
What would be most helpful in your role as a clinical supervisor?

Theme	Associated quotations
Increased awareness of student learning needs	"Understanding...the kind of objectives for the student and what they want to learn." (P1M)
	"It's good to get some idea of what the students are being taught, so you can understand the student a little better." (P6M)
	"Understanding where the student should be at, what the expectations are at different stages throughout the course and what the focus should be." (P7M)
	"A little bit more knowledge about the student...about their academic record would assist us. It would be nice to know what they are interested in: do they like surgery, do they like biomechanics, do they like geriatrics? Then we can look at the week we've got and make it work for them." (P8F)
	"What would be of benefit? I guess, is to give a brief snapshot of where students are coming from ...not thousands of pages of here you go, read this!" (P9F)
	" …to break down those barriers with the student." (P10F)
	"One thing I found helpful from the universities, it's really good to see how they set up the courses, so you know what to expect from a student coming from that Uni ...understanding that, gives a lot more perspective… sometimes when we have students that are not performing as well, that is something I think could be improved." (P11F)
Specific clinical supervision training opportunities	"Communication strategies with students: How to provide feedback effectively." (P2M)
	"How to give feedback …Self-awareness of how you are as a supervisor, so what your strengths are as a supervisor and how to use them effectively so that you're not burnt-out …I would say managing the poor performing students." (P3F)
	"Have someone from the Uni actually go out and run through some case scenarios, get them (the supervisors) to practice a little bit on what potentially would be a good case study for a learning experience." (P4M)

Theme	Associated quotations
	"The art of giving feedback. What else? Probably the whole concept of feedback and the right way to go about it without disheartening the students or being too soft on them. Just knowing the right approach to take." (P5F)
	"I think probably placement days at the University clinic with the students and the clinical supervisors ...I just find there is such a huge variation in podiatry on how podiatrists treat patients." (P6M)
	"I think also just some guidance on maybe some tips and techniques to use in passing on information, teaching styles." (P7M)
	" …networking opportunities for people to come together …for [supporting] staff members because we want to give them [the students] a really good experience and we want them to get a lot out of it." (P10F)
	"In terms of actual training...it's probably more support [from the universities] … sometimes when we have students that are not performing as well, that is something I think could be improved." (P11F)

IV DISCUSSION

Most supervisors felt unprepared for their role as clinical supervisors, recognising the difference between being a skilled practitioner and being an effective clinical educator. In their view, their general lack of preparedness stemmed largely from little or no formal clinical supervision training, with little or no guidance from the university prior to becoming and whilst being clinical supervisors. This finding highlights the often-erroneous assumption that clinical training and experience is adequate preparation for being a supervisor; the lack of supervisor training contributory to such opinions of under preparedness and low self-efficacy. Based on some of their responses, particularly from the less experienced clinical supervisors, some appear to be 'caught' in the initial 'role shock' stage of Watkins' (1990) model, i.e. still becoming used to the idea of being a supervisor, feeling overwhelmed and unprepared and lacking confidence. Much like Bradley and Boyd (1989) suggest, a hesitant, unsure supervisor cannot offer the leadership required in a supervisory position.

Whatever 'training' that had been offered, which may have been as little as an information handbook, was appreciated. This is not surprising considering that participating in training can positively affect motivation and increase awareness of learning needs during supervision (Martin et al., 2014) and can also develop a sense of self and related identity as a clinical supervisor (Higgs & McAllister, 2007). In Watkins' (1990) model, developing a supervisor identity often occurs in the second stage (Watkins, 1993), although this identity is fragile and can be shaken when confronted with supervisory difficulties particularly related to a beginning supervisor experiencing difficulty "shifting gears" from clinician to supervisor (Ladany & Bradley, 2001, p. 41). Clinical supervisor training should, therefore, be consistent, ongoing and provided in such a way that it can be evaluated on a regular basis (Kilminster & Jolly, 2000; Martin et al., 2014) and not ad hoc as these clinical supervisors described. During the interviews, several of the supervisors referred to their years engaged as supervisors as 'time spent doing it'. In terms of Kolb's (1984) theory of experiential learning whereby knowledge is created through the transformation of experience, for some, the experience of being a supervisor and conducting supervision, in itself appears to have influenced their own learning transition (Todd & Storm, 2014), despite the lack of formal training. This goes some way to validating 'turning experience into learning' (Akella, 2010) and it is perhaps through this experience and time on task that supervisors have had the opportunity to confront any challenges that span the Watkin's (1990) stages to enable personal growth as supervisors (Watkins, 1993).

On the whole, clinical supervisors were acutely aware of the need to extend their skills as facilitators of learning (Higgs & McAllister, 2007; Mulcahy et al., 2018; Needham et al., 2016), as evidenced by what they deemed would be helpful for their professional development. Some, however, lacked personal motivation to pursue further supervision training and/or development themselves, with many expecting the universities to provide it. Ladany and Bradley (2001) in fact

caution supervisors to think about what they wish to accomplish before selecting a supervisory role, given he or she has accepted the responsibility of supervising a student and is ultimately responsible for all the clients on the student's caseload. Martin and colleagues (2014) reinforce the point that undertaking training in clinical supervision is known to develop supervision skills.

A clinical supervisor has dual roles; a practitioner and an educator. Not surprising, the challenges many identified reflected a conflict in the clinical setting, i.e. supervising students required divided attention in a time-pressured clinical environment, which would be exacerbated if some students lacked interest and motivation. However, knowing more about students, such as their level of training and what they had studied, would provide clarity for the clinical supervisor in determining exactly what was required of them when working with and relating to the student (Johnson et al., 2012), as prior knowledge has long been deemed the most important factor for influencing student learning and achievement (Hailikari et al., 2008). In line with Kolb's learning stages, clinical supervisors were left unable to ensure the activities were appropriate if they were uncertain of the student's past educational experiences (McLeod, 2013). Furthermore, individuals with higher role clarity are expected to be more efficacious and to perform better (Bray & Brawley, 2002) and it is this reported uncertainty (e.g. unclear expectations, identifying only as a clinician, standards of competent performance not uniform) that probably prevents some supervisors from moving into Watkin's third stage of role consolidation, with a more established sense of identity as clinical supervisors (Watkins, 1993).

Most clinical supervisors were aware of their training needs, i.e. how to provide feedback and supervision styles. Some were also willing to receive feedback on their own performance as educators involving being self-aware of one's strengths and weaknesses. According to Ramani and Leinster (2008, p.358), soliciting feedback on one's own teaching is evidence of the "right person doing it" in dual roles in the clinical environment. A few wanted to also observe teaching sessions at the university to improve their supervisory skills. Such responses demonstrated ways to maintain a facilitative learning environment and to manage self and others, which would go a long way for them to reach a higher level of openness, competence and skill in supervision, in line with role consolidation and being able to recognise and address supervisory transference (Watkins, 1990). Further, several clinical supervisors acknowledged their part in ensuring responsibility for quality supervision, which in itself showed comprehension and self-awareness of their position in clinical education and of their impact on student professional development (Higgs & McAllister, 2007), and also reflective of varying degrees of role consolidation and role mastery (Watkins, 1990). The few who demonstrated possible role mastery were those who felt not only prepared but had a sense of confidence in their ability and skills to supervise. This became evident from their views of being 'professionally effective', through comments like being of a certain calibre, and being 'facilitative' by wanting to offer students a good learning experience.

Feeling underprepared, generally unsupported and overwhelmed as clinical supervisors is not unique to the podiatry profession (Rodger et al., 2008; Sealey et al., 2015; Thomas et al., 2007). Facing burnout and feeling time-constrained is also reflective of low levels of agency and self-efficacy (Shoji et al., 2016). With exhaustion comes adverse outcomes in terms of growth and change (Higgs & McAllister, 2007). Support should be available for clinical supervisors to overcome such challenges so that they can provide quality effective supervision and improve through appropriate professional development. Better communication between the universities and clinical supervisors is clearly required, as concluded by Gonsalvez and colleagues (2017) in their study of Australian psychology clinical supervisors' supervisory practices.

A *Limitations*

Despite several requests for research participants, recruitment was low. Notwithstanding this limitation, this phenomenological study allowed in-depth exploration of what it means to be a clinical supervisor of pre-registration podiatry students on placement; resulting in identifying underlying areas about the topic and further deemed appropriate because of the exploratory nature of this research.

V CONCLUSIONS

This study is probably the first to explore Australian podiatry clinical supervisors' perceptions of their preparedness to supervise students on placement. It identified that many clinical supervisors feel underprepared for their role as supervisors and, based on Watkin's (1990) supervisor development model, podiatry clinical supervisors are perhaps 'caught' between the recognised stages of development, as most received little or no training or support from the university or health service. Better understanding of the expectations required of students, provision of feedback to students and effective use of related supervision approaches, with increased motivation (intrinsic and extrinsic) to promote supervisor development are required to improve supervisory skills. Whilst challenges in the clinical setting are not unique, clinical supervisors should be able to access additional support to promote clarity and reduce any unnecessary burden associated with the responsibilities of clinical supervision. As the clinical supervisor role is distinct from that of a clinician, professional development is required to upskill clinical supervisors. It is incumbent on the universities to support (educationally and even financially) the ongoing professional development of its clinical supervisors. In doing so, this will reinforce the importance of effective clinical supervision, improve supervisor self-efficacy, and hopefully have long-term positive impact on graduate (and patient) outcomes.

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Appendix 1

Primary research question: How prepared are clinical supervisors to supervise podiatry students on placement?
As a clinical supervisor responsible for ensuring students' clinical experience: • What training or educational support have you received from the university or health service to assist you in your role as a clinical supervisor? • Was the training, studying, etc. useful? If Yes, why? If No, why not? Explain. • If your University or health service had to offer a suite of training/educational support, what would be most helpful in your role as a clinical supervisor? • What challenges have you faced as a clinical supervisor of podiatry students? • Concluding: In your experience, generally, how prepared are podiatrists for clinical supervision? • Whose responsibility is it to ensure quality clinical supervision?