From clinician to educator: Transformative learning processes among early-career allied health faculty in community colleges

by

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A.A.S, Western School of Health, and Business Careers, 2002
B.S., City College, 2015
M.S., Stayer University, 2017

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

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Abstract

The transition from clinical practice to academic teaching presents distinct challenges for allied health professionals entering faculty positions at community colleges. Although these professionals bring substantial clinical knowledge and experience, many have limited formal preparation in instruction, curriculum development, and the broader responsibilities of teaching. This generic qualitative study explored how early-career allied health faculty experienced the transition from clinical practice to academia and developed their professional identities as teachers.

The study was guided by Beauchamp and Thomas's (2009) conceptualization of teacher identity as a dynamic and evolving construct shaped by personal, relational, contextual, and professional experiences. Mezirow's (2000) transformative learning theory provided a conceptual lens for examining how participants reconsidered established assumptions and developed new perspectives as they adapted to academic teaching. Using purposive sampling, 14 allied health faculty members with one to five years of teaching experience following careers in clinical practice participated in semi-structured interviews. Data were analyzed inductively using Braun and Clarke's (2006) reflexive thematic analysis. Six themes emerged: new faculty slowly embraced a professional identity as teachers rather than clinicians; new faculty transformed their understanding of teaching through the limitations of clinical expertise; new faculty expanded their teacher identity through a commitment to student learning and success; new faculty developed innovative perspectives through academic collaboration and self-directed learning; new faculty established their professional identity through academic and professional accountability; and new faculty transformed their teaching practices through reflection and adaptation.

The findings revealed that becoming a teacher involved more than transferring clinical knowledge into the classroom. Participants described learning to communicate clinical concepts in ways that supported student understanding, adapting instruction to different learning needs, navigating academic responsibilities, and reconsidering their roles as educators. Their accounts illustrated how teacher identity developed through experience, relationships, reflection, and increasing confidence in the academic environment. The findings also demonstrated elements of transformative learning as participants questioned assumptions about teaching, recognized limitations in their clinical preparation, explored new approaches, and modified their instructional practices.

The study highlights the importance of intentional institutional support during the transition from clinical practice to academic teaching. Community colleges and allied health programs should provide practical faculty development, meaningful mentorship, opportunities for collaboration, and continued support for reflective teaching practices. By recognizing that clinical expertise does not automatically translate into instructional competence, institutions can better support clinicians as they develop into educators responsible for preparing the next generation of healthcare professionals.

Keywords: allied health education, clinical-to-academic transition, teacher identity, transformative learning, faculty development, community colleges, clinical preceptorship, qualitative research.

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To the future CCLP students who will begin this journey after us: welcome. You are about to embark on an experience that is intellectually demanding, personally revealing, occasionally humbling, and somehow uphill both ways, even when the weather is perfectly reasonable. Expect the occasional snowstorm of revisions, a sleet-filled forecast of deadlines, and the distinct possibility that your carefully organized plans will be buried beneath an avalanche of reading, research, and writing. There may be moments when you question your topic, your timeline, your organizational skills, and possibly your original decision to enroll. Keep going, keep moving forward, keep pushing yourself toward success.

Ask questions. Accept feedback. Find your people. Give yourself permission to learn, to revise, and to become a stronger version of the leader you were when you began. Do not mistake a difficult chapter for a failed journey, and do not assume that feeling uncertain means you are incapable. Sometimes uncertainty is simply the space in which growth happens.

Most importantly, remember why this work matters. The future of community college leadership depends on people willing to think critically, lead with integrity, challenge established practices when necessary and remain committed to the students and communities these institutions serve. Your degree is not simply a credential to place after your name. It is preparation for a responsibility. The communities you serve will need leaders who understand that education changes lives and that community colleges remain essential to opportunity, workforce development, and social mobility.

And if you find yourself wondering whether you can finish, let me leave you with this: if I can do this, so can you. There is no magic formula, no perfectly straight path, and certainly no

shortage of moments when the finish line seems farther away than it did the week before. There is, however, the next page, the next revision, the next conversation, and the next opportunity to keep moving forward. Take them one at a time. Someday, you will look back at the work that once seemed impossible and realize that you made it through. When that day comes, I hope you will remember the people who helped you and make room to encourage the next person to come behind you.

Finally, I dedicate a special measure of gratitude to the neurodivergent people of the world. This work is for you, too.

Too often, people are measured against a narrow definition of how a person should think, learn, communicate, organize, or demonstrate their abilities. Differences in attention, processing, learning, or perspective can be misunderstood as limitations rather than recognized as part of the diversity of human experience. When people are expected to succeed by following only one prescribed path, their potential can be overlooked before they have a fair opportunity to demonstrate it.

My hope is that this dissertation contributes, in its own small way, to a broader understanding of how people learn, how people grow, and how important it is to create environments in which individuals can develop their abilities. Education should not require everyone to think alike. Leadership should not require everyone to approach problems in the same way. And success should not be reserved for those whose minds happen to fit the expectations of a particular system. We need educators and leaders who recognize that different perspectives can strengthen classrooms, workplaces, institutions, and communities.

To those who have been made to feel that they were not smart enough, organized enough, focused enough, or capable enough to pursue something meaningful, I hope you will keep

questioning that judgment. A difficult path does not mean you do not belong on it. Needing a different approach does not mean you are less capable. And taking longer to reach a goal does not diminish the value of reaching it.

This dissertation is the product of years of learning, reflection, persistence, and growth. If its findings reinforce anything beyond the transition from clinician to teacher, I hope it is the importance of recognizing potential before it is fully realized and supporting people as they discover what they can become. That principle matters in higher education, in community college leadership, and in every environment where people are given the opportunity to learn and grow.

To everyone who helped me reach this milestone, thank you for your part in the journey. To those who are still working toward a goal that sometimes feels impossibly far away, keep going. The road may be long, the climb may be steep, and the weather may be terrible, but the view from the other side is worth the effort.

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Dedication

Some people help shape our story in ways that stay with us forever. Some are no longer here to see the final chapter, yet their love, influence, and fingerprints remain woven on every page. Others are still here, having walked beside us through life, watching us grow, stumble, persevere, and become who we are meant to be. This dissertation is dedicated to my parents, my children, and the people whose love and presence have helped shape the person I am today.

To the memory of my mother, Linda McGaffic: Mom, I wish you could be here to see this. I wish I could call you, hear your voice, and tell you that your baby boy finally did it. I wish I could hand you this dissertation and watch your face light up with that smile I know so well. Through every late night, every setback, every moment of doubt, and every time I wondered whether I could keep going, I carried your love with me. I can picture you looking down on me with that proud smile, saying, "That's my baby boy." Everything I have accomplished carries a piece of the love, strength, and lessons you gave me. I hope you know that I carried you with me all the way to this moment. I love you to the moon and back, Momma. Your baby boy finally did it.

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You will each have your own path to follow, your own challenges to face, and your own definition of success to discover. I do not expect your paths to look like mine. I only hope you always know that you are capable of more than you may sometimes believe that your worth is never measured by a title or an achievement, and that you never have to earn my love by becoming anything other than yourselves. If this doctorate teaches me anything worth passing on to you, it is that perseverance matters, growth is possible, and the most meaningful accomplishments are the ones that allow us to become better versions of ourselves. No matter where life takes you or how much time passes, you will always be a part of everything I do and everything I hope to become. I love you both more than words on these pages could ever express. This achievement is mine, but the love behind it includes you.

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imagining that you were there in your own special way. You are missed, Carmen, and you will always be part of this journey.

This dissertation is also dedicated to the allied health faculty who teach today and those who will enter the classroom tomorrow. To the clinicians who become educators, to the faculty who quietly carry the weight of their students, programs, professions, and institutions, and to those who sometimes wonder whether they are making a difference, this work is for you.

May you never forget that becoming a teacher is a journey, shaped in part by those who believed in us before we could fully see what we could become. To every allied health educator who continues to show up, keeps learning, and pours into others: may your impact live on long after you leave the classroom.

Chapter 1 - Introduction

Within allied health education, many clinicians transitioned into community college faculty roles primarily based on their disciplinary expertise, rather than through formal preparation in pedagogy, curriculum design, or the attainment of professional educator competencies (American Association of Community Colleges [AACC], 2022; Wilson et al., 2023). While clinical mastery provided the necessary foundational content knowledge, the academic environment demanded a sophisticated evolution of one's professional self-concept. This transition was not merely a matter of skill acquisition; it necessitated a fundamental renegotiation of how individuals understood and enacted their educator role, consistent with the view of professional roles as a dynamic, multifaceted, and contextually negotiated construction (Beauchamp & Thomas, 2009).

The movement from the clinical setting to the classroom often presented a disorienting dilemma (Mezirow, 2000), where established clinical identities were challenged by the academic and institutional expectations of higher education. The study explored how clinicians interpreted and described shifts in professional transition to academia and examined whether elements of transformative learning were evident in those interpretations. By examining these through the lens of transformative learning theory, this research provided a framework for understanding the profound cognitive and professional changes required for early-career faculty to successfully transition from clinician to academician.

Statement of the Problem

While allied health clinicians possessed advanced technical expertise, many experienced significant transformative tension upon entering academic roles, as clinical competence did not automatically translate into educator roles. These challenges created tensions between

established clinical identities and emerging academic expectations, requiring clinicians to interpret, negotiate, or redefine their professional roles (Keith et al., 2023). Insufficient transitional support contributed to ongoing shortages of qualified allied health faculty, disrupting student pathways to graduation at a time when the healthcare workforce depended heavily on these programs (Weissman, 2022). Community colleges played a substantial role in preparing allied health professionals; however, less was known about how clinicians transitioning into faculty roles reconstructed their professions within these institutions. Existing research had emphasized workforce preparation and faculty shortages, yet limited research examined the transformative processes that shaped early-career allied health educators.

Background of the Problem

The background of this problem was rooted in the growing demand for qualified clinical instructors within allied health programs, particularly in community college settings. As workforce shortages persisted, expert clinicians, many of whom already served as preceptors or clinical instructors, were increasingly recruited into formal academic roles. Although these individuals often brought valuable instructional experience, the expectations, accountability structures, and institutional norms of higher education required a fundamental renegotiation of their professional roles. Transitioning from clinician to educator presented distinct challenges, as faculty had to move beyond clinical expertise to develop proficiency in areas aligned with national benchmarks, including Instructional Strategies and Student Success (AACC, 2022).

Despite their central role in training the healthcare workforce, many clinicians began teaching without formal preparation in instruction, curriculum design, or assessment (Wilson et al., 2023). National data highlighted this preparation gap, indicating that 78% of new faculty felt unprepared for the classroom environment, with only 12% possessing prior training in

curriculum development (Wilson et al., 2023). Consequently, this transition often triggered a disorienting dilemma (Mezirow, 2000), necessitating a shift in teacher transformation as individuals reconciled their clinical expertise with the multifaceted requirements of the academic role (Beauchamp & Thomas, 2009).

Limited preparation was often accompanied by fragmented institutional support structures. Clinicians transitioning into faculty positions might encounter minimal access to structured professional development, mentorship, or role-specific orientation aligned with academic expectations (Carnell, 2024). In a qualitative study examining early-career professionals transitioning into educational roles, participants reported that their transformative development was shaped significantly by mentoring relationships, institutional culture, and perceived legitimacy within academic communities. Feelings of uncertainty and role ambiguity were common during early stages; however, structured support and collegial engagement facilitated increased confidence and professional integration over time (Myers, 2024). These findings underscored the importance of institutional context in shaping how clinicians interpreted and adapted to academic expectations.

Such conditions could contribute to uncertainty regarding instructional competence and professional expectations, influencing how clinicians perceived and interpreted their emerging roles within academic environments. These circumstances suggested that the transition involved not only the acquisition of instructional skills but also ongoing professional negotiation within a new institutional context (Beauchamp & Thomas, 2009).

Although allied health programs played a critical role in workforce development, scholarships had largely emphasized curriculum skill acquisition rather than examining how clinicians interpreted and made meaning of their transition into academic roles. Existing

literature frequently addressed the technical dimensions of teaching, the "what" of instruction, while giving less attention to how clinicians understood the "who" of their evolving professional role within the academic setting. Without a clearer understanding of how clinicians experienced and interpreted transitional challenges, institutions might struggle to design supports that fostered instructional confidence and long-term faculty retention.

These issues were particularly salient in community colleges, which educated substantial numbers of allied health professionals while serving historically underserved populations (Kopko et al., 2023). High instructional demands, diverse student learning needs, and limited preparation for teaching responsibilities might shape how early-career faculty navigated their roles and sustained engagement in the profession.

Strengthening instructional readiness among early-career allied health faculty was essential to preparing graduates for contemporary clinical practice. In the absence of structured curriculum preparation, new faculty often relied on personal initiative, informal peer networks, and experiential learning to adapt to academic expectations. While such strategies might support adjustment, they also highlighted the need for systematic professional development aligned with institutional objectives and evidence-based instructional practices (Wilson et al., 2023; Carnell, 2024;).

Within allied health education, emphasis on clinical competency frequently coexisted with traditional instructional approaches, including high-stakes examinations. Emerging research had explored competency-based assessment models that more closely aligned with applied clinical practice (Nieminen, 2022). However, variability in classroom preparation might influence how faculty interpreted and responded to these instructional expectations (Nieminen, 2022).

The transition from clinician to educator might also involve ambiguity regarding role expectations. Mesimer (2024) found that new faculty often accepted academic positions with limited clarity about their instructional and institutional responsibilities. Shifting expectations, accountability measures, and accreditation standards might create experiences that prompted clinicians to reflect on prior assumptions about teaching and their professional transformation. Such reflection was conceptually consistent with transformative learning theory, which described how individuals might reassess established frames of reference in response to challenging experiences (Fleming, 2018; Mezirow, 2000). However, the extent and nature of these reflective processes among community college allied health faculty remained insufficiently understood.

Accreditation standards further shaped the professional environment in which clinicians transitioned into academic roles. The Commission on Accreditation of Allied Health Education Programs (CAAHEP, 2019; CAAHEP, n.d.) outlined discipline-specific standards designed to ensure entry-level competence. Similarly, the Accreditation Commission for Education in Nursing (ACEN, 2023) required that faculty demonstrate appropriate qualifications, participate in orientation and mentoring, and engage in ongoing evaluation. These standards established institutional expectations for instructional competence and professional preparation, potentially influencing how clinicians interpreted their responsibilities and defined effective educator practice within accredited programs.

Although research had examined faculty transition within nursing and four-year institutions, limited scholarship addressed the experiences of non-nursing allied health clinicians entering faculty roles in community colleges. Given the central role of community colleges in allied health workforce development, this gap constrained understanding of how clinicians navigated the transition from clinical practice to academia.

Purpose of the Study

The purpose of this study was to explore how clinicians experienced and made meaning of their transition from clinical practice to community college faculty roles, including how they interpreted their evolving professional roles as educators. The study focused specifically on early-career allied health faculty who had transitioned from clinical practice into academic roles within community colleges.

Research Questions

The research focused on the following questions:

1. How do clinicians describe the evolution of their professional roles during the transition from clinical practice to academic roles?
2. How do these faculty members describe the transformative learning processes encountered during the transition from clinical practice to the academic environment?

Theoretical and Conceptual Frameworks

Beauchamp and Thomas's Teacher Identity

This study was grounded in Beauchamp and Thomas's (2009) teacher identity as active, socially constructed, and continuously negotiated through professional interactions and reflective processes. Within this framework, the teacher role was not viewed as something newly acquired upon entry into academia, but as something already enacted in practice and subsequently reshaped within new professional contexts. Allied health clinicians frequently engaged in teaching through precepting students, orienting new hires, and mentoring colleagues, and therefore often entered academic roles with an existing sense of themselves as educators. For this reason, Beauchamp and Thomas's framework was well-suited as the overarching theoretical

lens, as it allowed the study to examine how these pre-existing clinician–teacher identities were renegotiated rather than newly formed.

Surrounding the study in this way positioned the transition from clinical practice to academia as a process of professional role evolution rather than a simple role change. Early-career allied health faculty were understood to bring established identities grounded in clinical expertise and informal teaching, which were then reshaped through interaction with students, colleagues, and institutional expectations within community college settings. This perspective enabled the study to explore how participants reinterpreted their prior experiences considering new academic responsibilities, including curriculum design, student assessment, and adherence to institutional and accreditation standards.

Within this theoretical framing, professional role development was viewed as contextually mediated and influenced by both interpersonal and structural factors. Clinicians transitioning into faculty roles had to reconcile their confidence and authority as practitioners with the expectations and norms of higher education, often creating tensions that required ongoing negotiation. Beauchamp and Thomas's (2009) framework emphasized that such negotiation occurred through reflective processes, professional dialogue, and participation in new communities of practice.

Applied to this study, the framework directed attention to how clinicians drew upon their clinical values, such as precision, critical thinking, and patient-centered care, while adapting to the pedagogical, relational, and accountability demands of academia. In doing so, it provided a coherent structure for understanding the transition as an evolving process of professional role reconstruction grounded in experiences that began well before entry into formal teaching roles.

Mezirow's Transformative Learning

Transformative learning theory (Mezirow, 2000) provided the conceptual framework for examining how clinicians critically reflected on prior assumptions and reconstructed their professional roles in academia. This theory highlighted the cognitive and reflective processes through which individuals reinterpreted experiences, challenged established perspectives and underwent meaningful professional transformation. As Mezirow (2000) explained, transformative learning was defined as:

> the process by which we transform our taken-for-granted frames of reference, to make them more inclusive, discriminating, open, emotionally capable of change, and reflective so that they may generate beliefs and opinions that will prove truer or justified to guided action. (p. 8)

Mezirow further emphasized that transformation often occurred through "reflection, dialogue, and engagement in disorienting dilemmas" (p. 22), experiences that challenged clinicians' established clinical assumptions and prompted a professional transformative reconstruction.

To provide conceptual clarity for the reader, Mezirow's (2000) transformative learning theory was further articulated through ten phases that described how individuals might experience perspective transformation. These phases included: (1) experiencing a disorienting dilemma; (2) engaging in self-examination; (3) conducting a critical assessment of assumptions; (4) recognizing that one's experience was shared with others; (5) exploring new roles, relationships, or actions; (6) planning a course of action; (7) acquiring knowledge and skills for implementing new roles; (8) provisionally trying new roles; (9) building competence and self-confidence in those roles; and (10) reintegrating into one's professional life with a revised perspective.

For the purposes of this study, these ten phases were not treated as linear or required stages, but rather as sensitizing concepts used to guide the development of interview questions and support the interpretation of participants' meaning-making processes (Fleming, 2018). This conceptual framework was particularly relevant for clinicians whose pre-existing identities as clinical experts or preceptors had to evolve to encompass educator responsibilities within academic contexts.

As they encountered unfamiliar instructional demands, some clinicians might reexamine their beliefs and practices through reflection, while others might reinforce or maintain prior assumptions (Mezirow, 2000; Fleming, 2018). Mezirow's theory thus illuminated the processes through which early-career allied health faculty navigated institutional barriers and supports that shaped cohesive educator identities.

Methodology

This study deployed a generic qualitative research approach to explore allied health clinicians transitioning into teaching roles in community colleges. Qualitative studies are characterized by their flexibility, as they:

> Exhibit some or all the characteristics of qualitative endeavor but rather than focusing the study through the lens of a known methodology, they seek to do one of two things: either they combine several methodologies or approaches or claim no methodological viewpoint at all, Caelli et al. (2003, p.2)

A qualitative approach was appropriate for this study as it allowed for an in-depth exploration of participants' experiences, perspectives, and meaning-making processes during the transition from clinician to educator. Within this approach, a qualitative design was employed, as it provided flexibility to examine how individuals interpret and describe their experiences

without being bound to the specific requirements of established qualitative traditions such as phenomenology or grounded theory (Kahlke, 2014). This adaptability is particularly beneficial for exploring the experiences of clinician-educators, as it allowed for the integration of multiple perspectives and insights without being constrained by a single methodological framework.

Alignment Table

See Appendix A for the alignment table, which depicts the progression from the literature to the research questions, the conceptual framework, the interview questions, aligned with the conceptual framework, and the 10 phases of Mezirow's transformative learning theory, illustrating how each component is systematically connected to the study's purpose.

Delimitations and Assumptions

This study includes several delimitations, intentional boundaries established to narrow the research focus, and assumptions that underpin the research design. The scope of this investigation was focused on allied health programs within the community college setting and intentionally excluded four-year institutions and non-allied-health disciplines to maintain contextual consistency. The scope was limited to programmatically accredited allied health programs, ensuring that participants worked within established expectations for faculty qualifications and instructional quality rather than evaluating specific professional development initiatives. Within these parameters, the primary emphasis of the inquiry was on participants' perceptions of their transition and emerging educator transformation.

This study proceeded based on two primary assumptions. First, participants would provide honest and accurate accounts of their transition experiences and reconstruction processes, despite the inherent limitations of self-reported data such as social desirability bias or retrospective distortion.

Second, early-career allied health faculty possessed sufficient reflective capacity to describe their transition experiences and discuss whether they encountered moments of tension, uncertainty, or reassessment in their professional roles, consistent with Mezirow's (2000) transformative learning processes.

Significance of the Study

This study addressed a critical gap in understanding how allied health clinicians experienced and interpreted their professional transformations as they transitioned from clinical practice to academic roles. Beauchamp and Thomas's (2009) teacher identity framework was used to examine how participants negotiated and reconstructed their professional identities within this shift. Separately, Mezirow's (2000) transformative learning theory was used to explore the processes through which participants made meaning of their experiences and navigated changes in perspective.

While national benchmarks for community college faculty emphasized instructional competence and student success (AACC, 2022), these standards provided little guidance for the profound career transformation clinicians faced when translating clinical mastery into instructive practice. The significance of this study lay in its potential to inform institutional support structures, such as targeted mentoring and professional development, that went beyond technical training to address the psychological and professional shifts inherent in the transition. Ultimately, by fostering a more successful transition for early-career faculty, this research supported faculty retention, contributed to the quality of allied health instruction, and ensured a robust pipeline for the future healthcare workforce.

Definition of Terms

Allied Health Faculty. Educators teaching in allied health programs at community colleges who meet the minimum professional requirements established by their programmatic accrediting body and who often transition from clinical practice to academia without formal teaching experience (Wilson et al., 2023).

Allied Health Programs. Post-secondary education programs are designed to train healthcare professionals in specialized fields such as surgical technology, dental assisting, and medical laboratory sciences. These programs in community colleges serve as critical workforce pipelines (Kopko et al., 2023).

Competency-Based Assessment. An evaluation approach that measures student proficiency in real-world clinical skills rather than traditional high-stakes testing (Nieminen, 2022).

Critical Assessment of Assumptions. Clinicians engage in self-examination to evaluate the validity of their prior beliefs about teaching, learning, and professional roles, identifying which clinical assumptions no longer serve them in the academic context (Fleming, 2018, p. 123).

Didactic. For the purposes of this study, didactic refers to the instructional component of the faculty role that involves the delivery, facilitation, and assessment of knowledge-based content in an allied health discipline at a community college.

Early-Career Faculty. For the purposes of this study, early-career allied health faculty are defined as individuals with one to five years of teaching experience in a community college setting who have transitioned from clinical practice into academic roles. These individuals typically possess prior instructional experience in clinical environments, such as precepting,

mentoring, or training students or staff, and may be employed in either part-time (adjunct) or full-time faculty positions within accredited allied health programs.

Faculty Development. Structured professional learning opportunities designed to enhance teaching effectiveness, assessment strategies, and curriculum design among educators. This includes workshops, mentoring programs, and formal classroom training (Carnell, 2024).

Institutional Support. Resources provided by colleges to assist faculty in their transition to teaching, including professional development programs, mentorship, and curriculum resources. Institutional support is a moderating factor in faculty preparedness (Tinto, 2023).

Teacher. For purposes of this study, a teacher is defined as an allied health clinician who assumes responsibility for facilitating the learning and development of others and who develops, negotiates, and enacts an identity through the knowledge, relationships, practices, reflection, and contextual experiences associated with teaching.

Chapter Summary

Chapter 1 presented an overview of the study, encompassing the problem statement, relevant background information, and the purpose of this study. It articulated the central research questions guiding the investigation. Furthermore, this chapter introduced the theoretical and conceptual frameworks that underpinned the study, supplemented by an alignment table to illustrate their connections. The research methodology was also outlined, providing clarity on the approach taken. In its conclusion, Chapter 1 addressed the delimitations and assumptions inherent in the study, highlighted the study's potential significance, and defined key terminology essential for understanding the research context.

Organization of the Study

The study was structured into five cohesive chapters, each building upon the last to create a seamless narrative. Chapter 1 provided an overview of the study. Following this, Chapter 2 offered a literature review, exploring key themes such as faculty development, the transition from clinical practice to faculty roles, and effective teaching strategies within allied health education. Chapter 3 provided the methodology of the study. Chapter 4 presented the findings of the study, including the themes and patterns that emerged from the participants' accounts of their transition from clinical practice to community college faculty roles. The findings were organized according to the research questions and reflected participants' experiences, perceptions, and interpretations of their evolving professional roles as educators. Chapter 5 provided a discussion of the findings, connecting the results to the theoretical and conceptual frameworks and the existing literature. This chapter interpreted the meaning and implications of the findings, addressed the research questions, discussed implications for allied health education and community college practice, and presented recommendations for future research.

Chapter 2 - Review of the Literature

This literature review examined the transition from clinical practice to academia as a significant professional shift that extended beyond changes in workplace setting. This literature review was organized into ten major topics: 1) the literature search, 2) theoretical and conceptual frameworks, 3) teaching transition and the negotiation of educator transformation, 4) early-career faculty transitions in allied health, 5) institutional development as a catalyst for transformation, 6) mentoring and the construction of faculty belonging, 7) facilitators and barriers to early-career faculty success, 8) professional transformation, 9) national standards and the definition of faculty excellence, and 10) gap in current literature.

The Literature Search

This literature review examined existing research related to clinician-to-faculty transition, professional transformation reconstruction, and transformative learning within the context of allied health education in community colleges. The search was conducted using Kansas State University's library databases, including the Educational Resources Information Center (ERIC) and ProQuest Dissertations and Theses Global. Most sources were published between 2000 and 2024, with foundational literature dating back to 1981. Additional relevant articles were identified through Google Scholar to support comprehensive coverage. Search terms included clinician-to-faculty transition, allied health education, professional transformative learning, and competency-based assessment in community college allied health programs.

Theoretical and Conceptual Frameworks

Beauchamp and Thomas's (2009) teacher identity framework provided the theoretical foundation, conceptualizing professional role as dynamic, negotiated, and socially constructed

through ongoing interactions, narratives, and institutional contexts. Building on this, transformative learning theory (Mezirow, 2000) offered a conceptual framework for understanding the reflective and cognitive processes through which transformation might occur as clinicians encountered disorienting dilemmas, questioned prior assumptions, and made meaning of their new roles.

Theoretical Framework

This study was guided by Beauchamp and Thomas's (2009) teacher identity framework, which conceptualized professional role as dynamic, socially constructed, and continuously negotiated within specific professional contexts. Rather than treating the role transition as a stable attribute, the framework asserted that teacher identity was "dynamic, rather than stable, and is shaped and reshaped in interaction with others in a professional context" (Beauchamp & Thomas, 2009, p. 177). Self-understanding developed through iterative processes of reflection, relational engagement, and negotiation of institutional expectations.

The teacher identity theory, as articulated by Beauchamp and Thomas (2009), provided the overarching theoretical framework for this study by conceptualizing professional roles as dynamic, socially constructed, emotionally laden, and continually negotiated through interaction with others and institutional contexts. Within this perspective, role transition was understood as an evolving process, shaped through narrative, reflection, and participation in professional communities rather than as a fixed role or set of traits (Beauchamp & Thomas, 2009). This framework underpinned the present study's focus on how allied health clinicians entering community college faculty positions renegotiated their professional identities as they moved from primarily clinical work into academic roles (Beauchamp & Thomas, 2009).

Related scholarship on educator roles illustrated how this kind of theoretical orientation could be applied in different ways and with different emphases. Olsen (2008) employed a teacher-identity lens to examine how teachers' reasons for entering the profession, life history, and commitments to broader purposes shaped their emerging and evolving identities over time. In his analysis, role transformation functioned to understand why some teachers sustained engagement in the profession while others experienced dissonance and considered leaving (Olsen, 2008). Although Olsen's work preceded Beauchamp and Thomas's (2009) explicit formulation, his attention to identity as evolving, contextual, and connected to personal purpose was consistent with their later characterization of a professional role as dynamic and socially negotiated. In contrast, the present study used Beauchamp and Thomas's (2009) framework directly to illuminate how clinicians described becoming teachers, focusing on how they reconstructed their professional identities as they crossed the boundary from clinic to classroom rather than on long-term retention decisions.

Rodgers and Scott (2008) also engaged the teacher role as a core construct, but they emphasized the narrative and relational dimensions of transformation development. They argued that professional role transformation was multiple, shifting, and constructed in and through stories teachers told about themselves, their students, and their work, shaped by discourse, relationships, and historical context (Rodgers & Scott, 2008). Their synthesis foregrounded narrative as a key site in which role transition work became visible and emphasized the importance of teachers' ongoing meaning-making about their practice (Rodgers & Scott, 2008). The present study aligned with this view by attending closely to clinicians' narratives of transition and by interpreting those narratives through Beauchamp and Thomas's (2009) conception of identity as dynamic and emotionally inflected. At the same time, it extended

Rodgers and Scott's focus by applying these ideas to faculty whose prior professional identities had been formed in clinical rather than school-based settings.

Smagorinsky and colleagues provided a further complementary perspective on teacher development, focusing on the tensions that arose as novices negotiated competing expectations in practice contexts. They conceptualized professional self-concept as co-constructed through participation in cultural practices and examined how preservice teachers accommodated or resisted institutional norms while developing as educators (Smagorinsky et al., 2004). Their work highlighted the conflicts that emerged when personal beliefs about good teaching collided with the realities of school environments and showed how such tensions shaped professional trajectories (Smagorinsky et al., 2004). The present study similarly attended to tensions, but in a different arena: allied health clinicians confronted misalignments between a well-established clinical role orientation and the demands, discourses, and evaluation structures of educator roles, and Beauchamp and Thomas's (2009) framework was used to analyze how participants negotiated these conflicts in constructing their roles as educators.

Taken together, these studies demonstrated that teacher development was a robust and flexible theoretical construct that had been used to examine career trajectories and decisions (Olsen, 2008), narrative and relational dimensions of becoming a teacher (Rodgers & Scott, 2008), and the negotiation of tensions in early practice (Smagorinsky et al., 2004), all in ways that resonated with Beauchamp and Thomas's (2009) emphasis on professional self-concept as dynamic, context-dependent, and socially mediated. The present study was consistent with this body of work in treating professional self-concept as evolving and negotiated, but it diverged in population and setting by applying Beauchamp and Thomas's (2009) framework explicitly to

allied health clinicians transitioning into community college faculty roles. In doing so, it extended prior work into a context where professional role development had been primarily grounded in clinical practice.

Conceptual Framework

Mezirow's (2000) transformative learning theory served as the conceptual framework for this study, providing a lens to examine the internal, reflective processes through which clinicians reconstructed their professional transformation to academic roles. The theory explained how adults responded to disorienting dilemmas by critically assessing taken-for-granted assumptions, engaging in reflective discourse, and developing more inclusive meaning perspectives that guided future action (Mezirow, 2000). In this study, all ten phases of transformative learning were used to comprehensively frame these processes, allowing for a structured yet flexible exploration of participants' experiences across the full trajectory of perspective transformation.

Empirical applications of transformative learning theory supported its relevance in professional and educational transitions. For example, Cranton and Kasl (2012) used the theory as an analytic lens to examine how collaborative discourse among adult educators facilitated shifts in teaching assumptions, highlighting critical reflection as a catalyst for transformation. Similarly, Laros et al., (2017) found that perspective transformation in professional development contexts often occurred incrementally through sustained reflection rather than discrete, dramatic events. These findings supported the use of a flexible, non-linear application of all ten phases of transformative learning in this study.

Building on this foundation, this study applied Mezirow's framework to the specific context of clinicians transitioning into community college faculty roles. All ten phases were used

to guide the development of the interview protocol, ensuring that questions captured the range of experiences from initial disorienting dilemmas through critical reflection, exploration of new roles, and eventual integration of revised professional identities. In doing so, transformative learning theory functioned as a conceptual structure that guided interpretation of participants' narratives, illuminating the intrapersonal meaning-making processes that accompanied transformative development in early academic roles.

Teaching Transition and the Negotiation of Educator Transformation

The transition from clinical practice to academic roles in allied health education presented a multifaceted challenge that began with a fundamental negotiation of professional self-concept. Myers (2024) found that for many clinicians, educator transformation was not an immediate acquisition but a process that emerged through the tension between established clinical expertise and developing pedagogical competence. Further stating that early-career faculty initially positioned themselves as clinicians who happened to teach, rather than as educators with a distinct professional role (2024). Over time, this role was refined through reflective engagement and relational validation from colleagues, marking a shift from a clinical expert to a novice academician (Myers, 2024). This internal shift was central to the transformative learning process, as faculty had to eventually reinterpret their professional roles to resolve the conflict inherent in moving away from the bedside or chairside.

Building upon this internal transitional work, the research by Aziz (2026) and Cobourne (2022) emphasized the social and institutional mechanisms required for faculty to feel fully integrated into their new roles. Aziz (2026) defined a sense of belonging (SB) as a dynamic construct shaped by an individual's perception of being valued within the institutional hierarchy.

This sentiment was echoed by Cobourne (2022), who argued that targeted mentoring served as the primary vehicle for fostering this sense of value and ensuring long-term career satisfaction. In the community college setting, where clinicians often navigated the gap between their former medical communities and their new academic environments, the absence of these social supports could lead to a fragmented professional transformation and increased turnover.

While the internal and social aspects of professional transformation were critical, recent literature also highlighted the structural frameworks and systemic factors that dictated the success of this transition. Willess (2023) examined the structural side of professional development, identifying the institutional factors and personal persistence required for doctoral students to complete their degrees. This research suggested a parallel for faculty: the same support systems vital for student persistence, clear expectations, structured timelines, and institutional resources, were also critical for faculty belonging and retention. However, Willess (2023) noted that persistence was often a result of the interaction between the individual's drive and the institution's ability to provide a clear path forward.

The complexity of this transition was further compounded by the specific demands of the community college environment. Gonzalez-Bosch (2024) identified cultural competency and student-centered strategies as vital components for faculty supporting diverse learners. The demands of the community college required a specialized pedagogical focus that differed from university research models. Gonzalez-Bosch (2024) identified “cultural competency and student-centered strategies” (p. 78) as the most vital components for faculty development in this sector, suggesting that a one-size-fits-all approach to training was insufficient for allied health educators. Unlike university-based faculty development, which might prioritize research and

grants (Haas, 2023), community college development had to address the immediate, practical needs of the classroom. This focus on equity and culturally responsive pedagogy, as advocated by Keith et al. (2023), suggested that true institutional integration could not occur without a proactive commitment to social justice. For the allied health instructor, mastering the classroom involved not only teaching clinical skills but also dismantling systemic barriers that had historically impeded student success.

Furthermore, practical evidence supported the link between robust faculty development and measurable student outcomes. Elliott and Oliver (2016) found that professional development activities in community colleges were strongly linked to improvements in teaching strategies and student achievement. Their research highlighted that when faculty development was embedded in the mission, goals, and policies of the institution, it was viewed as vital rather than elective. This direct connection between the educator's growth and the student's success provided a compelling argument for institutions to move beyond simple onboarding toward sustained, relationship-based frameworks that validated the clinician's expertise while supporting their growth as an academician.

Ultimately, the synthesis of this literature suggested that while clinicians possessed high levels of clinical expertise, they entered the academic environment underprepared for the specific demands of instruction and curriculum design. As Banks (2024) and Covas (2022) argued, structured professional development served as the stabilizing mechanism that bridged this gap. Whether it was through digital competency training (Sadiq et al., 2024) or interprofessional education (Babin et al., 2023), these programs acted as the contextual sites where transformative learning development occurred. By providing a structured space for reflection, these initiatives

allowed early-career faculty to finally adopt an educator role that was both personally rewarding and institutionally grounded.

Early-Career Faculty Transitions in Allied Health

The transition from clinical practice to academic roles within community colleges presented complex challenges that affected both faculty development and educational quality. Early-career faculty often encountered structural and systemic barriers, including limited access to updated curricular materials and significant gaps in pedagogical knowledge. While Mesimer (2024) emphasized the personal stress of this expansion of duties, the impact was magnified in the community college setting. Here, the outdated teaching methods identified by Carnell (2024) did not just affect individual faculty confidence; they created systemic barriers to the educational quality required to serve diverse student populations. This suggested that the early-career transition was not merely a personal hurdle but an institutional one that required structural intervention.

Carnell (2024) noted that delays in curricular updates could compel faculty to rely on outdated teaching methods, potentially hindering the design of learning experiences that were engaging and aligned with modern program objectives. These challenges were compounded by a broadening of responsibilities that extended far beyond clinical expertise to include committee work and institutional obligations. Mesimer (2024) observed that this expansion of duties created acute role ambiguity and stress, contrasting sharply with the clearly defined, task-oriented nature of clinical settings. The transition was often marked by an unexpected increase in cognitive labor that clinicians found difficult to bound. One educator described this shift as a “persistent mental

load" that felt "all-consuming" (Mesimer, 2024), contrasting sharply with the clearly defined tasks found in clinical practice.

The selection of a one-to-five-year period for this study aligned with established theoretical models of faculty development. Specifically, Schoening (2011) posited that the transition from clinician to educator was a multi-phase process, beginning with anticipatory expectations and moving through disorientation, that typically required five years to reach the final phase of integrity or full role integration. By focusing on faculty within this window, the study captured the most intense periods of transformative growth described in the Nurse Educator Transition Model (Schoening, 2011). This timeframe was critical, as it represented the period where the sense of belonging described by Aziz (2026) was most fragile; without intervention during these five years, the disorientation phase might lead to burnout rather than professional actualization.

Institutional support served as the primary mechanism for mitigating these transitional hurdles. Structured faculty development, including formal orientation and ongoing mentorship, helped new educators synthesize clinical knowledge with classroom practice. Beauchamp and Thomas (2009) emphasized that such support was "critical in the ongoing negotiation of teacher identity" (p. 177), enabling faculty to gain professional legitimacy. These programs were particularly vital in community college contexts where faculty served culturally diverse and non-traditional student populations. As Keith et al. (2023) suggested, institutional support also had to be equity-minded, ensuring that the transition process accounted for the diverse backgrounds of both the faculty and the students they served.

Individual reflections further highlighted the cognitive and emotional adjustments required; Mesimer (2024) noted that academic work often felt all-consuming, creating a persistent mental load that was absent in bound clinical tasks. This shock at the breadth of faculty responsibilities suggested a dual reality: while allied health faculty brought invaluable clinical expertise, they remained novices in the academic landscape. Ultimately, the literature indicated that successful transitions were supported by longitudinal, reflective practice (Goldman, 2025; Rhett-Davis, 2023), whereas a lack of structured guidance led to slower role integration and decreased occupational commitment (Smith, 2022). This synthesis underscored that the transformation of a clinician into a confident educator was not an accidental byproduct of time, but a deliberate result of targeted institutional investment.

Institutional Development as a Catalyst for Transformation

Faculty development in allied health education constituted a critical component of the institutional context within which early-career clinicians interpreted their transition into teaching. While these initiatives were often evaluated through the narrow lens of student outcomes, their deeper influence lay in shaping the professional role construction of the transitioning clinician. Faculty development provided a structured environment where educators could engage in the reflection and reinterpretation of professional assumptions required to negotiate an emerging educator transformation (Banks, 2024; Covas, 2022). For clinicians entering academia, participation in these programs often prompted a fundamental reconsideration of instructional assumptions, facilitating the integration of classroom strategies into established clinical expertise. Research indicated that structured professional learning significantly bolstered faculty confidence and clarity in instructional design (Chew, 2023; Falusi et al., 2023). By examining

these experiences through a transformative learning lens, it became possible to analyze how such institutional engagement contributed to the profound role shifts of early-career allied health faculty.

Although student performance indicators were the traditional measure of faculty development success (Tinto, 2023), such metrics failed to capture the internal cognitive shifts experienced during role transition. From a transformative learning perspective (Mezirow, 2000), the focus shifted to how faculty reconstructed their professional roles within the academic setting. Tinto (2023) asserted that an inclusive learning environment was shaped not only by content expertise but also by an educator's "confidence and cultural competence" (p. 57). This underscored a shift in roles from a mere "subject matter expert" to an intentional, culturally responsive educator. This was particularly evident in the community college sector, where Chew (2023) found that structured development led to a greater capacity to support diverse learners. Similarly, Falusi et al. (2023) illustrated that evidence-based training resulted in "stronger interactions with students" (p. 44), suggesting that pedagogical mastery was a primary driver of professional self-legitimacy.

While much of the literature on health professions faculty development addressed university-based programs or medical centers, there was a notable gap in research specifically targeting community college allied health instructors. In community college settings, faculty often balanced teaching, administrative responsibilities, and ongoing clinical practice, which presented unique challenges for professional development. Gonzalez-Bosch (2024) identified "cultural competency and student-centered strategies" (p. 78) as particularly relevant for faculty supporting diverse learners, suggesting that faculty development programs in community

colleges had to address both classroom skills and student diversity. Empirical evidence further supported the impact of faculty development on instructor development. Hyson et al. (2021) found that professional development programs at community colleges influenced instructors' perceptions of teaching, fostering changes in classroom approaches, student engagement, and active learning strategies. These findings supported the concept of a practical instructor, one who adapted classroom strategies to meet student needs while maintaining instructional rigor.

Professional development also promoted relational and community-focused teaching. Conley (2025) documented how participation in structured learning communities enhanced faculty collaboration and encouraged instructors to adopt relational strategies, including more responsive communication and consideration of student experiences. Such approaches aligned with the broader goal of developing empathetic and culturally responsive educators capable of fostering inclusive learning environments. In contrast to university-based models that emphasized research productivity and leadership, community college faculty development prioritized instructional practice and relational competencies that directly affected student engagement and retention.

The availability, or lack, of structured faculty development could significantly influence how clinicians interpreted, negotiated, and internalized their emerging identities as educators. Collectively, this body of research underscored the pivotal role that comprehensive faculty development initiatives played in advancing instructional quality, strengthening faculty role formation, and improving student outcomes within community college allied health programs. In this study, such faculty development initiatives were treated not as the primary object of

investigation but as one of several contextual influences shaping how early-career allied health faculty experienced transition and educator role development.

Mentoring and the Construction of Faculty Belonging

The scholarly landscape concerning faculty and student development in higher education revealed a complex interplay between institutional support, personal transformation, and professional persistence. While the research by Aziz (2026) and Cobourne (2022) emphasized the internal and social mechanisms required for faculty to feel integrated into their roles, studies by Willess (2023) and Keith et al. (2023) shifted the focus toward institutional frameworks and systemic equity as the foundation for growth. Specifically, Aziz (2026) defined a sense of belonging as a dynamic construct shaped by an individual's perception of being valued, a sentiment echoed by Cobourne (2022), who argued that targeted mentoring was the primary vehicle for fostering this value and ensuring career satisfaction. Conversely, Willess (2023) examined the structural side of professional development by identifying the institutional factors and personal persistence required for doctoral success, suggesting that the same support systems vital for student persistence were equally critical for faculty belonging. Ultimately, as suggested by Keith et al. (2023), these support frameworks had to be viewed through an equity-minded lens to ensure that the sense of belonging described by Aziz (2026) was accessible to all faculty, regardless of their background or clinical discipline.

The cultivation of this sense of belonging (SB) was increasingly recognized as a foundational prerequisite for faculty retention, yet its manifestation within the community college remained a complex, multi-layered phenomenon. Aziz (2026) highlighted that for health professions educators (HPEs), belonging was a phenomenological experience deeply tied to an

individual's perception of being valued and respected within the institutional hierarchy. This transition was often fraught with tension as clinicians navigated the gap between their former medical communities and their new academic environments. While Smith (2022) suggested that mentoring and intercollegiate collaboration were key drivers in mitigating this isolation, Aziz (2026) argued that belonging was a dynamic construct shaped by the continuous interaction between an educator's personal preferences and the social climate of the college. Consequently, for the early-career faculty member, the transition was not merely a change in job description but a negotiation of cultural and social integration within a new professional home.

Building upon the necessity of social integration, the presence of formal and informal mentoring structures served as a critical bridge for enhancing career satisfaction and the intent to remain in academia. Cobourne (2022) emphasized that mentoring significantly impacted faculty engagement, providing the necessary psychosocial support to navigate the trial by fire atmosphere often experienced by novice educators. This was particularly relevant in the community college setting where, as Smith (2022) noted, a lack of structured training programs, such as the two-to-six-week intensives desired by many, left a void that only robust mentoring could fill. Cobourne's (2022) findings suggested that when mentoring was intentionally implemented, it fostered a stronger sense of professional commitment, which directly countered the high turnover rates currently plaguing allied health education. Thus, mentoring was more than a social support; it was a critical site for role negotiation. Understanding how participants perceived this support was essential for answering this study's research questions regarding professional transformation.

Facilitators and Barriers to Early-Career Faculty Success

Early-career allied health faculty encountered a diverse array of mentorship structures, onboarding protocols, and institutional guidance that significantly dictated the trajectory of their transition into academia (Carnell, 2024; Wilson et al., 2023). These contextual factors did more than provide logistical support; they actively shaped how individuals interpreted role expectations and assessed their own professional preparedness. Rather than positioning these conditions as mere deficits, this study explored how such environmental facilitators and barriers interacted with the individual's internal meaning-making processes and transformative role development.

Systemic expectations, particularly those mandated by accreditation bodies such as the Higher Learning Commission (2024), further formalized the requirements for ongoing professional development and instructional effectiveness. These standards created a secondary layer of pressure, influencing how clinicians negotiated the gap between their established clinical expertise and the burgeoning demands of their academic roles. Joy et al. (2022) highlighted that these demands were directly linked to student retention and workforce readiness, asserting that "faculty equipped with advanced curriculum strategies and a deep understanding of competency-based education are better positioned to foster student success" (p. 89). This suggested that a barrier to faculty success, namely, insufficient instructional training, functioned as a direct barrier to student achievement, reinforcing the necessity for a systematic approach to professional development.

The interconnectedness of faculty retention and student outcomes was further evidenced by Weissman (2022), who identified insufficient curriculum preparation as a primary driver of

the faculty workforce shortage in allied health. When coupled with Joy et al.'s (2022) emphasis on workforce readiness, a clear picture emerged: the transition was not merely an individual hurdle but a systemic vulnerability. Weissman (2022) advocated for a model of development that integrated curriculum design and assessment strategies as a retention tool, arguing that supportive learning environments were essential to mitigate the shock of entering the academic workforce.

Perhaps the most significant barrier to successful transition was the profound work-role conflict triggered by the move from clinical expert to academic novice. Rhett-Davis (2023) conceptualized this journey through a three-phase heuristic model consisting of surmounting, stabilizing, and actualization. In the initial "surmounting" phase, new faculty had to navigate the psychological loss of their clinical role, a struggle frequently exacerbated by the absence of formal pedagogical training. This aligned with the findings of Smith (2022), where participants described a trial by fire entry into the classroom and expressed a significant desire for intensive two-to-six-week training programs to bridge the gap between patient care and student instruction. Without formal institutional structures to support the stabilizing phase, Rhett-Davis (2023) warned of long-term role fragmentation, where the educator never fully reconciled their clinical past with their academic present.

Professional Transformation

Within allied health programs operating in community college settings, formal accreditation standards and institutional expectations served as the primary architecture for faculty professional growth. The Association of College and University Educators (ACUE, 2023) conducted a comprehensive study demonstrating the significant positive impact of

structured development on teaching effectiveness. When development was structured and sustained, the results were measurable at the classroom level. Their findings indicated that faculty who participated in intentional professional development reported "significant improvements in their ability to engage students, design effective curricula, and implement evidence-based teaching strategies" (p. 14). These outcomes underscored the importance of shifting the institutional view of faculty training from an elective activity to a core requirement for enhancing educational quality.

ACUE (2023) further emphasized that these programs advanced broader institutional goals, including improved student retention and academic achievement. This aligned with a growing body of research suggesting that faculty pedagogical competence was the most critical factor in fostering effective learning environments, particularly in settings serving diverse student populations that required tailored instructional approaches. However, a persistent preparedness gap remained among clinicians entering academia. While clinicians possessed deep subject matter expertise, they often lacked the formal scaffolding required for complex curriculum design. Without targeted preparation, new faculty might have struggled to develop curricula that aligned program objectives with the evolving needs of the healthcare workforce, creating a disconnect between clinical reality and classroom instruction.

Further reinforcing this need for targeted support, Smith (2024) examined community college faculty perceptions of their roles in supporting the academic achievement of minoritized students. The study emphasized that pedagogical skill must have been paired with cultural competence and empathy, noting that "a student-centered approach is vital for fostering academic success among diverse populations" (p. 33). Smith (2024) highlighted that ongoing

institutional support was the primary factor enabling faculty to adopt these culturally responsive practices. These findings complemented the ACUE (2023) research by demonstrating that structured faculty development must have addressed both the technical skills of teaching and the relational dimensions of the educator-student dynamic.

Collectively, this research highlighted the inextricable link between structured professional learning and the refinement of instructional practice (ACUE, 2023; Smith, 2024). While ACUE (2023) focused on the measurable changes in instructional design and student engagement strategies, Smith (2024) underscored the necessity of inclusive approaches in supporting non-traditional student populations. Within the specific context of allied health education, these professional development expectations operated alongside accreditation requirements and institutional policies.

National Standards and the Definition of Faculty Excellence

Within allied health programs operating in community college settings, professional growth was often informed by national benchmarks that defined the multifaceted nature of the faculty role. The American Association of Community Colleges (AACC, 2022) provided a recognized framework of core competencies, including Instructional Strategies, Student Success, and Community College Culture. These standards represented the professional expectations for faculty excellence within the sector and served as a resource for institutions designing development programs. For the early-career allied health faculty member, these competencies outlined the transition from a clinical focus to an instructional one.

While clinicians entered with mastery of their craft, they might have lacked the formal scaffolding to meet national expectations for community college instruction. The AACC (2022)

highlighted that faculty must have moved beyond subject expertise to master “instructional strategies and student-centeredness,” a requirement that created a “disorienting dilemma” for those accustomed only to clinical roles.

However, the literature suggested a persistent gap between these national standards and the trial by fire reality experienced by many clinicians entering academia (Smith, 2022). While the AACC (2022) emphasized proficiency in learning design and student-centeredness, many allied health educators began their careers with deep clinical expertise but limited exposure to these specific academic requirements. This disconnect created a disorienting dilemma (Mezirow, 2000), where the individual had to reconcile their clinical roles with a broad set of national professional expectations. In this context, the AACC competencies were referenced not as an analytical framework for this study, but as the established professional landscape within which the participants' role development transformed. While these competencies provided a clear institutional target, they did not account for the internal, subjective experience of the educator.

Gap in Current Literature

No research examined how early-career, non-nursing allied health faculty in community colleges interpreted their professional transition through a transformative learning lens. Much of this work emphasized curriculum skill acquisition and teaching techniques, rather than the deeper psychological and professional transformations required as clinicians became faculty. Research rarely applied Mezirow’s transformative learning theory to examine how early-career allied health faculty in community colleges reinterpreted prior assumptions, made sense of role change, and reconstructed professional transformation during the clinical-to-academic role transition. Consequently, little was known about how these new faculty described and navigated their own transformative learning as they adapted clinical expertise to classroom instruction.

This study addressed that gap by foregrounding the transformative learning processes through which allied health clinicians became community college educators.

Chapter 3 - Methodology

This chapter presents the methodology for the study, including the purpose of the research and the guiding research questions. It outlines the theoretical and conceptual frameworks that informed the study, as well as the research design and criteria for site selection. The chapter described the criteria for participant selection, instrumentation, and methods for data collection and analysis, including an alignment table linking research questions, conceptual framework and interview questions. It also addressed potential limitations, procedures to ensure study quality and trustworthiness, and ethical considerations relevant to the research process.

Purpose of the Study

The purpose of this study was to explore how clinicians experienced and made meaning of their transition from clinical practice to community college faculty roles, including how they interpreted their evolving professional roles as educators. The study focused specifically on early-career allied health faculty who had transitioned from clinical practice into academic roles within community colleges.

Research Questions

The research focused on the following questions:

1. How do clinicians describe the evolution of their professional roles during the transition from clinical practice to academic roles?
2. How do these faculty members describe the transformative learning processes encountered during the transition from clinical practice to the academic environment?

Theoretical and Conceptual Frameworks

Teacher identity functioned as the theoretical framework, positioning participants as entering academic roles with pre-existing conceptions of themselves as educators, often shaped through clinical teaching experiences such as precepting, mentoring, and skill instruction. This framework provided the lens for understanding how these existing professional identities were constructed and carried into the academic environment.

Transformative learning theory served as the conceptual framework, guiding the examination of how participants reinterpreted, challenged, and reconstructed those prior identity assumptions as they transitioned into formal academic roles. This framework directed attention to the reflective, cognitive, and meaning-making processes through which clinicians made sense of the shift from clinical teaching to institutionalized educator responsibilities.

This study used Beauchamp and Thomas's (2009) teacher identity framework to conceptualize professional roles as socially constructed, evolving, and continually shaped through reflection and interaction in academic contexts. The framework viewed the role of the teacher as "dynamic, rather than stable, and shaped and reshaped in interaction with others in a professional context" (p. 177), with reflection functioning as "a factor in the shaping of identity" (p. 180). Applied to allied health clinicians transitioning from clinical practice and preceptorship, this lens highlighted how established clinical identities transformed through engagement with institutional expectations, colleagues, students, and classroom experiences.

Mezirow’s (2000) transformative learning theory served as the guiding conceptual framework for this study, shaping both the research and interview questions. The theory provided a structured way to examine how clinicians interpreted and made meaning of their transition into community college faculty roles, particularly as they encountered challenges that

prompted reflection on previously held assumptions about their professional transformative process. Through practices such as critical reflection, reflective discourse, and perspective transformation, the framework supported an in-depth exploration of how participants experienced and made sense of their transformative shifts over time. This framework informed the design of the semi-structured interview protocol, with questions developed to elicit rich descriptions of participants' experiences across the trajectory of transformative learning.

Research Design

This study employed a qualitative design grounded in interpretivism. Interpretivism assumed that reality was socially constructed and that meaning was co-created through interaction between researcher and participant (Merriam & Tisdell, 2016). Because this study sought to understand how clinicians interpreted and made meaning of their professional role transition, an interpretive qualitative approach was most appropriate. While the study incorporated analytic techniques such as constant comparison, it did not adopt the procedural or philosophical requirements of a single established qualitative tradition.

This qualitative approach was selected because the study did not aim to: (a) identify the essential structure of a lived experience, as in phenomenology; (b) construct temporally ordered life histories, as in narrative inquiry; or (c) generate a formal theory grounded in data, as in grounded theory. Rather, the purpose of this study was to identify patterns of shared meaning across participant accounts of the transition from clinician to educator and to examine how participants interpreted and made meaning of that experience.

This design was particularly appropriate because it allowed for the systematic exploration of shared patterns in how early-career allied health faculty interpreted and made meaning of their

experiences, while maintaining flexibility in analytic approach. By not being bound to a single methodological tradition, this approach supported an in-depth, contextually grounded analysis of participants' perspectives, consistent with the interpretivist orientation of the study (Caelli et al., 2003). The focus on patterned meaning, rather than essence, narrative sequence, or theory generation, distinguished this study methodologically and aligned with its research purpose.

This study was further guided by a generic qualitative research approach as outlined by Percy et al. (2015), which was appropriate when the goal was to understand how individuals interpreted and made meaning of their experiences without adhering to the methodological constraints of a single qualitative tradition. Generic qualitative research was particularly suited for studies that sought to identify patterns of meaning across participants rather than to develop theory, establish essences of lived experience, or construct detailed life histories.

Consistent with this approach, the present study focused on how early-career allied health faculty described and interpreted their transition from clinical practice to academic roles. Data were collected through semi-structured interviews designed to elicit descriptive, experience-based narratives, and analyzed to identify recurring patterns of meaning across participants. This approach allowed for flexibility in design while maintaining methodological rigor through systematic data collection and analysis procedures aligned with the study's interpretivist orientation.

Site Selection

The study was conducted at community colleges that held regional accreditation recognized by the Council for Higher Education Accreditation (CHEA). Selected institutions offered accredited allied health programs that were in good standing with their respective

programmatic accreditors. Institutions were first identified through publicly available directories. This initial pool was then refined to include only those institutions where the relevant allied health programs also maintained current programmatic accreditation in good standing. This stepwise selection process ensured that all study sites were both appropriate to the research focus and situated within the regulatory context of accredited allied health education.

Following identification of eligible institutions through publicly available directories, recruitment of faculty was conducted through direct outreach to allied health program leadership. Program directors, department chairs, or deans associated with accredited allied health programs were contacted via email to introduce the study, describe its purpose, and request assistance in identifying eligible faculty participants. This approach ensured that recruitment occurred within appropriate institutional channels while maintaining alignment with the study's focus on accredited allied health programs within community college settings.

Study Participants

Participants were selected using purposive criterion sampling and consisted of early-career allied health faculty who had transitioned from clinical practice into academic roles within community colleges. Early-career faculty were defined as individuals with one to five years of teaching experience, representing the period in which professional transformation was most pronounced (Schoening, 2011).

Eligible participants currently served as allied health faculty members at a community college, had between one and five years of teaching experience in higher education, and possessed prior clinical experience in an allied health profession before transitioning to an academic role. Participants could be employed in either part-time (adjunct) or full-time faculty positions within accredited allied health programs at regionally accredited community colleges.

A sample of 12 to 15 participants was projected to achieve thematic sufficiency, defined as the point at which not substantively new related patterns emerged in relation to the study's theoretical constructs (Creswell & Poth, 2018). Participants had to (a) have transitioned from clinical practice to a part-or-full-time faculty role in an allied health program within the past five years, (b) be employed at a community college, and (c) teach in an accredited allied health discipline.

Participant recruitment occurred through a combination of direct and network-based strategies. Following institutional outreach, program leaders were asked to share study invitations with eligible faculty members who met the inclusion criteria. Interested participants were invited to contact the researcher directly to ensure voluntary participation and minimize any perceived coercion.

Additional participants were recruited through professional networks and discipline-specific organizations supporting allied health education. Snowball sampling was also utilized; whereby initial participants recommended colleagues who met the study criteria. This multi-pronged recruitment approach was intended to ensure a diverse sample across allied health disciplines and institutional contexts while maintaining alignment with the study's purposive sampling strategy.

Once the target community colleges were identified, recruitment of individual participants was initiated. This outreach was conducted by contacting allied health program leaders at those institutions, as well as leveraging professional networks and national organizations that supported community college health profession educators. Additional participants who met the eligibility criteria were identified through snowball sampling, if

necessary, to ensure representation across institutional contexts (Biernacki & Waldorf, 1981; Patton, 2015).

Snowball sampling was a non-probability sampling technique in which existing participants referred to or recruited additional participants who met the study's inclusion criteria (Biernacki & Waldorf, 1981; Patton, 2015). This approach was particularly useful for accessing hard-to-reach or specialized populations where a complete list of potential participants was unavailable. In this study, snowball sampling could be employed to recruit clinicians who had recently transitioned into community college faculty roles. Initial participants identified through accredited allied health programs could be asked to recommend colleagues with similar experiences, allowing the participant pool to expand.

Instrumentation

The researcher served as the primary instrument for data collection and analysis (Merriam & Tisdell, 2016; Moustakas, 1994). The 10-phases of Mezirow's (2000) transformative learning theory provided a framework for understanding how participants reconsider established assumptions and develop new perspectives through experiences that challenge their existing frames of reference. Mezirow described transformative learning through ten phases that illustrate how individuals may experience changes in their understanding, beliefs, and actions. These phases provided a conceptual foundation for examining how clinicians experienced the transition from clinical practice to academic teaching. Understanding the phases was particularly relevant to this study because participants entered faculty positions with established professional identities, clinical knowledge, and experiences that shaped how they initially understood their responsibilities. Transitioning into teaching required many participants

to reconsider aspects of their professional roles and develop new ways of understanding and approaching their work as educators.

The first phase, a disorienting dilemma, occurs when an experience challenges an individual's established expectations or understanding of a situation. This experience may create uncertainty because familiar assumptions or approaches no longer adequately explain the individual's circumstances. In the context of this study, accepting a faculty position and discovering that clinical expertise alone did not prepare an individual for the responsibilities of teaching could represent such an experience.

The second phase, self-examination with feelings of fear, anger, guilt, or shame, involves examining one's response to the experience that challenged previous assumptions. Individuals may experience uncertainty, frustration, or a loss of confidence as they recognize differences between their previous understanding and their current circumstances. For clinicians entering academia, this could involve questioning their ability to teach, feeling unprepared for academic responsibilities, or experiencing uncertainty about their effectiveness as educators.

The third phase, a critical assessment of assumptions, involves examining the beliefs and expectations that previously guided an individual's understanding and actions. Individuals begin to question whether their established assumptions remain appropriate in the new situation. For clinicians transitioning into teaching, this could involve reconsidering the belief that knowing how to perform a clinical procedure is sufficient preparation to teach someone else how to perform it. This phase reflects the recognition that clinical competence and instructional competence involve different knowledge and skills.

The fourth phase, recognition that one's discontent and the process of transformation are shared by others, involves realizing that other individuals have experienced similar challenges

and uncertainties. This recognition can help individuals understand that their difficulties are not necessarily personal shortcomings but may be part of a broader experience. Within the context of this study, new faculty members may recognize that other clinicians transitioning into academia have also experienced uncertainty, challenges with instructional preparation, and difficulty adjusting to academic expectations.

The fifth phase, exploration of options for new roles, relationships, and actions, involves considering alternative ways of understanding oneself and responding to the situation. Individuals begin to explore possibilities that differ from their previous perspectives. For clinicians entering academia, this could include considering new approaches to instruction, seeking guidance from experienced faculty, developing relationships with academic colleagues, and beginning to understand themselves as teachers rather than exclusively as clinicians.

The sixth phase, planning a course of action, involves identifying steps necessary to move forward with a revised understanding or perspective. Individuals begin considering what they need to do to address the challenges they have recognized. In an academic setting, this could involve identifying areas where additional preparation is needed, seeking professional development opportunities, or developing strategies for improving instructional practices.

The seventh phase, acquiring knowledge and skills for implementing new plans, involves developing the information, abilities, and resources necessary to carry out the identified course of action. For new faculty, this may include learning instructional strategies, developing lesson plans, understanding assessment practices, becoming familiar with academic technology, and gaining knowledge of institutional expectations. This phase highlights the importance of learning opportunities and institutional support during the transition into teaching.

The eighth phase, provisionally trying new roles, involves putting new perspectives into practice and experimenting with different ways of functioning. Individuals begin applying what they have learned while evaluating how well these approaches work. For clinicians entering academia, this could involve experimenting with instructional strategies, modifying classroom activities, changing how clinical concepts are explained, or assuming new responsibilities associated with the faculty role.

The ninth phase, building competence and self-confidence in new roles and relationships, involves developing greater ability and confidence through continued experience and practice. As individuals become more familiar with their responsibilities, they may begin to feel more comfortable and capable in their new roles. For early-career faculty, this could involve becoming more confident in classroom instruction, developing stronger relationships with students and colleagues, and increasingly recognizing themselves as educators.

The tenth and final phase, reintegration into one's life based on conditions dictated by the new perspective, involves incorporating the revised understanding into one's ongoing professional and personal identity. The individual begins functioning with a perspective that has been reconsidered and developed through the transformative learning process. In the context of this study, this could involve integrating the educator role into an established professional identity while continuing to draw upon clinical experience and knowledge. Rather than replacing a clinical identity, the development of a teacher identity may represent an expansion of how individuals understand their professional responsibilities.

Mezirow's (2000) ten phases provided a framework for understanding the potential processes involved in the transition from clinical practice to academic teaching. The phases were not treated as a required sequence or as stages that every participant was expected to experience.

Individuals may experience some phases more clearly than others, revisit earlier perspectives, or develop new understandings through different experiences. For this study, the phases served as conceptual points of reference for understanding how participants described challenges to established assumptions, reflection, the exploration of new approaches, and changes in their professional perspectives. The framework informed the development and interpretation of the interview protocol while allowing participants' experiences and the themes emerging from the data to remain grounded in their own accounts.

Prior to formal data collection, the semi-structured interview protocol was piloted with three volunteers who had varying levels of teaching and academic experience. The volunteers had 2, 5, and 8 years of experience, respectively. The volunteer with 8 years of experience also held a dean position, providing an additional academic leadership perspective. The purpose of the pilot testing was to assess the clarity, relevance, and flow of the interview questions and determine whether they appropriately addressed the study's research questions. Feedback from the volunteers provided an opportunity to identify questions that required clarification and consider whether the interview protocol would encourage participants to provide detailed descriptions of their experiences transitioning from clinical practice to academic teaching. The pilot testing informed the preparation of the interview protocol before data collection began. No data from pilot participants were included in the final analysis.

Data Collection and Data Sources

Data collection for this study followed a systematic step-by-step approach designed to ensure rigor, ethical integrity, and replicability. The process began with obtaining approval from the Kansas State University Institutional Review Board (K-State IRB), which was included in

Appendix B. Any additional approvals required from participating institutions were also secured to ensure full compliance with ethical standards for human subject research.

Following approval, data collection proceeded in a structured sequence. First, a pilot of the interview protocol (see Appendix C) was conducted to refine question clarity and alignment with the study's purpose. Next, letters of introduction and invitations to participate (see Appendix D) were sent to prospective participants. Upon expression of interest, informed consent was obtained (see Appendix E) prior to any data collection. Instructions for referring participants, outlining the snowball sampling procedure used to identify additional eligible faculty (see Appendix F) were shared prior to interviews.

Prior to each interview, participants completed a demographic data sheet to provide background information relevant to the study. During the interviews, the researcher maintained detailed notes to document key points, observations, and information that might require further consideration. Google Meet's transcription and Notes applications were also used as supplementary documentation tools to assist in capturing interview content and details that may not have been recorded in the researcher's notes. Following each interview, the recordings were downloaded and reviewed repeatedly by the researcher. Additional listening and review, including the use of the recordings during commutes, provided further opportunities to become familiar with participants' accounts and identify information requiring additional attention. The researcher used a mobile memo application to document additional notes and observations when necessary. These practices supported thorough engagement with the interview data throughout the research process.

Data collection then consisted of semi-structured interviews designed to elicit narratives regarding participants' professional journeys. The interview protocol specifically targeted the

intersection of participants' clinical backgrounds and their emerging academic roles, allowing for a "real-time in-depth conversation" (Aziz, 2026) on how individuals negotiated the transition from clinician to community college educator.

Once institutional approvals were in place, the researcher initiated participant recruitment. Recruitment occurred through email invitations and official announcements distributed via professional networks, institutional contact lists, or faculty contacts. The email invitation included a brief description of the study, the inclusion criteria, the voluntary nature of participation, and the anticipated time commitment. Prospective participants were directed to review the study's informed consent which clearly outlined the purpose of the study, procedures, potential risks and benefits, confidentiality measures, and their rights as participants, including the right to withdraw at any time without consequence. Participants provided written consent electronically or in person prior to participation. All recruitment communications included a description of the study, eligibility criteria, time commitment, and a statement emphasizing voluntary participation.

Primary data were collected through semi-structured interviews, each lasting 60 to 75 minutes. Interviews were scheduled at times convenient for participants and were conducted via a secure virtual platform (Google Meet) to facilitate transcription. Prior to the interview, participants were reminded of the purpose of the study, the voluntary nature of participation, and the procedures for maintaining confidentiality. With participant permission, all interviews were audio-recorded to ensure an accurate record of responses.

Following each interview, audio recordings were transcribed verbatim by the researcher and carefully reviewed for accuracy. Selected excerpts from each participant's transcript that

were used in the study's findings were sent to that participant for review, allowing them to clarify, elaborate, or amend their responses as needed.

Demographic data (see Appendix G) were collected using a brief inquiry form see that was administered prior to the interview. The inquiry form gathered information such as age, gender, years of teaching experience, program discipline, faculty rank or appointment type, and institutional setting. This information provided context for understanding participants' backgrounds and experiences and supported the interpretation of findings by allowing comparisons across demographic variables, highlighting patterns, and situating individual narratives within broader professional and institutional contexts.

All data were securely stored on a password-protected device accessible only to the researcher. Identifiable information was removed from transcripts and reports, and participants were assigned pseudonyms to protect their confidentiality. Data management procedures followed both IRB requirements and institutional policies to ensure the protection of participant information.

Throughout the data collection process, the researcher engaged in reflexive journaling to monitor potential biases, track decisions regarding interview questions and follow-up prompts, and document observations about participants' responses and the research environment. This journaling enhanced confirmability and provided an audit trail for dependability. Additionally, thick description of participants' experiences, combined with detailed contextual information about their institutional settings, ensured that the findings were transferable to similar populations or contexts.

By following this structured, step-by-step approach, the study ensured methodological transparency and rigor, enabling replication by other researchers interested in examining professional transition experiences among early-career allied health faculty.

Data Analysis

Data were analyzed inductively using reflexive thematic analysis as described by Braun and Clarke (2006). This approach was selected because it provides a systematic yet flexible process for identifying patterns of meaning across participants' accounts while allowing themes to develop from the data rather than being imposed in advance. The approach was consistent with the interpretivist orientation of the study and supported an examination of how participants described their experiences transitioning from clinical practice to teaching in higher education. The researcher conducted the coding and thematic analysis manually rather than using qualitative data analysis software.

Braun and Clarke's (2006) six-phase approach guided the analytic process. The first phase, familiarization with the data, involved reading and rereading each interview transcript to become immersed in the participants' accounts and to identify initial observations and potential areas of significance. During this phase, the researcher recorded reflective notes and observations regarding recurring concepts, experiences, language, and potential patterns within and across participant interviews. Familiarization continued throughout the analytic process as transcripts were revisited during subsequent phases of coding and theme development.

The second phase, generating initial codes, involved systematically reviewing the transcripts and identifying segments of data that were relevant to the research questions. Coding was conducted manually by the researcher, with codes developed inductively from participants' descriptions rather than from predetermined categories. Initial codes captured meaningful aspects

of participants' experiences, including their transition from clinical practice to teaching, development of teaching practices, adaptation of clinical expertise to student learning, relationships with students and colleagues, confidence and professional identity, mentorship and support, institutional and technological challenges, professional standards and accountability, and reflection and adaptation. Coding remained flexible and iterative, with codes being revised, combined, expanded, or reconsidered as the researcher progressed through the dataset.

The third phase, searching for themes, involved examining relationships among the initial codes and grouping related codes into broader patterns of meaning. The researcher compared coded excerpts across participants to identify similarities, differences, and recurring experiences. Related codes were organized into preliminary or candidate themes that represented broader aspects of participants' experiences. This process involved moving repeatedly between individual coded excerpts, the developing codes, and the dataset to determine whether the emerging patterns were supported across participant accounts.

The fourth phase, reviewing themes, involved evaluating the participant themes against the coded data and the complete dataset. The researcher examined whether the excerpts within each theme formed a coherent pattern and whether the themes were sufficiently distinct from one another. Themes were revised, combined, separated, or reorganized when further examination indicated that a different structure more accurately represented the participants' accounts. This iterative review also provided an opportunity to identify data that did not fit neatly within an emerging theme and to consider whether such data represented variation within an existing theme or warranted further analytic attention.

The fifth phase, defining and naming themes, involved refining the central meaning and boundaries of each final theme. The researcher reviewed the data associated with each theme to

identify the specific concept that unified the participant accounts and to distinguish each theme from the others. Theme names were developed to accurately reflect the content and meaning of the data while remaining grounded in participants' descriptions. The final thematic structure represented patterns identified across the 14 participant interviews and provided the organizational framework for presenting the findings in Chapter 4.

The sixth phase, producing the report, involved selecting participant excerpts that clearly illustrate the central concepts represented within each theme and integrating those excerpts with the researcher's analytic narrative. Selected quotations were reviewed in relation to their original interview context to ensure that they accurately represented participants' intended meaning. The findings were then organized according to the final thematic structure and presented in relation to the research questions.

Following the completion of the six phases of reflexive thematic analysis, the researcher reviewed the coded data and developing thematic structure across all 14 participant interviews. Initial codes that reflect related experiences or shared meanings were compared and grouped into broader patterns. These patterns were then examined across the dataset to determine whether they represent sufficiently coherent and distinct concepts to form final themes. The researcher returned to the original interview transcripts throughout this process to ensure that the developing themes remained grounded in participants' accounts.

The final themes were established through an iterative process of comparing individual coded excerpts, related patterns, and the complete dataset. Codes were combined when they represented overlapping concepts and separated when further examination demonstrated meaningful distinctions. Themes were also reviewed for internal coherence and conceptual distinction from one another. This process resulted in the final thematic structure presented in

Chapter 4. Table 3-1 illustrates the progression from representative initial codes to related patterns, and ultimately to the final themes identified across the participant interviews. Interpretation of the findings in relation to the theoretical frameworks and existing literature is addressed in Chapter 5.

Table 3-1 Development of the Final Themes

Representative Initial Codes	Related Patterns	Final Theme
Entering academia; leaving or expanding beyond clinical practice; new responsibilities; identifying as faculty; becoming a teacher; confidence; self-doubt; changing self-perception; teacher identity; belonging	Evolution of professional identity	New Faculty Slowly Embraced a Professional Identity as Teachers Rather Than Clinicians
Lesson planning; lectures; assessments; teaching strategies; preparing to teach; organizing content; classroom preparation; instructional methods; time management; grading; pedagogical development	Recognition of the difference between clinical expertise and teaching	New Faculty Transformed Their Understanding of Teaching Through the Limitations of Clinical Expertise
Translating clinical knowledge; different learning styles; modifying explanations; student success; guiding learners; questioning; critical thinking; relationships with students; student feedback	Student-centered teaching and learning	New Faculty Expanded Their Teacher Identity Through a Commitment to Student Learning and Success
Mentorship; colleagues; faculty support; leadership; guidance; onboarding; technology; Blackboard; grading systems; academic terminology; time management	Navigating the academic environment through support and self-directed learning	New Faculty Developed Innovative Perspectives Through Academic Collaboration and Self-Directed Learning
Standards; accreditation; accountability; patient safety; academic integrity; grading; evaluation; professional expectations; student preparation; faculty responsibility;	Faculty accountability and professional responsibility	New Faculty Established Their Professional Identity Through Academic and Professional Accountability
Reflection; trial and error; student feedback; changing approaches; learning from experience; instructional revision; experimentation; adaptation; continuous improvement	Reflective and iterative development	New Faculty Transformed Their Teaching Practices Through Reflection and Adaptation

As shown in Table 3-1 the overview of the analytic progression used to develop the final thematic structure, the codes and patterns shown are representative of the broader coding process and illustrate how participant accounts were progressively organized into themes. The resulting themes provide the organizational framework for the findings presented in Chapter 4.

Alignment Table

See Appendix A for the alignment table, which depicts the progression from the literature to the research questions, the conceptual framework, the interview questions, aligned with the conceptual framework, and the 10 phases of Mezirow's transformative learning theory, illustrating how each component is systematically connected to the study's purpose.

Limitations

Several limitations of this qualitative study were beyond the researcher's control and should be acknowledged when interpreting the findings. As with most qualitative inquiries, the results were context-specific and might not be transferable to all allied health faculty or community college environments, but it was hoped they might provide insights. Participant recruitment was limited to those who voluntarily agreed to participate, which might have introduced self-selection bias. Faculty members who decided to participate might have had particularly strong opinions or experiences related to professional development and transformative learning, while others who were less engaged or experienced might not have been represented.

Participant availability also posed a limitation, as scheduling interviews with part-time (adjunct) or full-time faculty working across multiple campuses and clinical settings was a bit challenging. Institutional policies and administrative procedures further influenced the timeline and accessibility of participants, with approval processes and communication restrictions,

potentially delaying data collection. Additionally, external factors such as workload demands, program accreditation cycles, and ongoing changes within higher education might have shaped the participants' perceptions in ways that were beyond the researcher's influence.

Ethical Considerations

This study adhered to the highest ethical standards in accordance with institutional guidelines. Prior to initiating data collection, approval was obtained from the Kansas State University Institutional Review Board (IRB). Participants were provided with detailed informed consent materials outlining the purpose of the qualitative study, procedures, potential risks, and their rights as participants. Participation was entirely voluntary, and individuals retained the right to withdraw from the study at any time without penalty.

Given the researcher's professional background in allied health education, reflexivity was intentionally embedded throughout the analytic process. The researcher maintained a reflexive journal to document assumptions, positionality, and potential biases that might influence interpretation. This practice enhanced transparency and supported methodological rigor. Member checking was also conducted by providing participants with selected excerpts intended for inclusion in the findings, allowing them to verify accuracy and confirm that their perspectives were appropriately represented.

Data collection occurred through semi-structured interviews conducted via a secure online video conferencing platform. Each participant was assigned a pseudonym to protect their identity, and all identifiable information was removed from transcripts and subsequent reporting. Prior to each interview, participants reviewed and signed the informed consent form, which included permission for audio recording. During the interview, the researcher maintained a

professional, respectful demeanor and ensured that participants felt comfortable sharing their experiences openly.

Audio recordings were transcribed verbatim and reviewed for accuracy by the researcher. Transcripts and recordings were stored on a password-protected device accessible only to the researcher. All data files, including consent forms, were securely maintained in compliance with institutional data protection policies. Participants were informed that their direct quotes might be used in the dissertation and related publications, but that no identifying information would be revealed.

Study Quality

To ensure the rigor, quality, and trustworthiness of the qualitative study, the researcher employed strategies aligned with Guba and Lincoln's (1994) criteria, addressing credibility, transferability, dependability, and confirmability. Credibility was supported through member checking. Following each interview, the audio recording was transcribed verbatim and reviewed by the researcher for accuracy. Selected excerpts from each participant's transcript that were intended for inclusion in the study's findings were then provided to the respective participant for review. Participants were invited to clarify the meaning of their statements, elaborate on their experiences, or identify inaccuracies or misinterpretations. Some participants provided corrections, clarification, or additional information during this process. Feedback received was considered to ensure that participants' perspectives were accurately represented in the presentation of findings.

Transferability was supported through detailed descriptions of the participants, their professional backgrounds, and the context of the study. The study included 14 early-career allied health faculty members representing six community colleges and multiple allied health

disciplines. Participants' clinical experience ranged from 7 to 36 years, while their teaching experience ranged from 1 to 5 years. Additionally, the findings chapter incorporated detailed descriptions of participants' experiences and direct quotations to illustrate how they experienced the transition from clinical practice to teaching. These descriptions provided readers with sufficient information to consider the relevance of the findings to early-career allied health faculty in similar community college settings.

An audit trail was maintained throughout the research and data analysis processes to document the progression of the study and provide transparency regarding analytic decisions. The researcher retained successive versions of coding records and thematic development documents, allowing changes in initial codes, related patterns, and emerging themes to be reviewed over time. These records documented the progression from individual participant statements to initial codes, the organization of related codes into broader patterns, and the refinement of the final six themes. Researcher interview notes and supplemental memos also provided additional documentation of observations and considerations recorded during data collection and review of the interview recordings.

For example, during the development of the first theme, participant descriptions of entering academia, assuming new responsibilities, experiencing confidence and self-doubt, and developing a sense of belonging were represented through initial codes. These codes were organized into the broader pattern of the evolution of professional identity and ultimately contributed to the final theme, for example, Theme 1: New Faculty Slowly Embraced a Professional Identity as Teachers Rather Than Clinicians. This progression illustrates how participant accounts were organized into increasingly developed analytic concepts while remaining connected to the original interview data. Successive versions of the coding records

provided documentation of this analytic development and the decisions made during theme refinement.

Reflexive journaling was conducted throughout the research process to examine the researcher's professional positionality, assumptions, and potential influence on data collection and interpretation. Given the researcher's professional experience in allied health education, particular attention was given to recognizing how prior knowledge of academic environments and the transition from clinical practice to teaching could shape the interpretation of participant experiences. The reflexive journal provided a place to document personal reflections, consider potential biases, and examine whether interpretations were grounded in participants' accounts rather than the researcher's professional expectations. Revisiting these reflections during analysis supported an ongoing awareness of the researcher's role in the interpretive process.

Together, the audit trail and reflexive journal supported methodological transparency, dependability, and confirmability. The audit trail documented the development of the analytic process, while reflexive journaling provided a record of the researcher's ongoing consideration of positionality and interpretive decisions. These practices helped maintain a transparent connection between the original participant accounts, the development of codes and related patterns, and the final thematic structure.

All physical research records containing participant information are maintained in a secure location with restricted access to the researcher. Electronic research data, including interview recordings and transcripts, are stored on a password-protected external storage device maintained by the researcher. Access to research data is limited to the researcher and dissertation committee members, as necessary for research oversight and dissertation review. Research records will be retained in accordance with Kansas State University Institutional Review Board

requirements and institutional data-retention policies. Following the required retention period, audio recordings and other identifiable research data will be permanently destroyed using appropriate secure disposal methods.

The researcher also remained mindful of potential technological, or transcription errors arising from the use of transcription software and virtual interviews and recognized that time constraints might have limited opportunities for extended engagement or follow-up interviews. By integrating these strategies, the study maintained rigorous standards of transparency and trustworthiness, ensuring that the findings provided an authentic, meaningful, and credible account of early-career allied health faculty transition experiences.

Chapter Summary

This chapter detailed the qualitative research design employed to investigate the transition experiences of clinicians entering faculty roles within community college allied health programs. Emphasizing participants' narratives, the study sought to understand how clinicians experienced and interpreted their transition into community college faculty roles and how they described their evolving professional identities. The next chapter presented the findings of the thematic analysis, incorporating participants' reflections and insights.

Chapter 4 - Findings

Chapter 4 presents the findings of the study and is organized into four sections. The chapter begins with a presentation of the participant demographics, providing context for the 14 allied health faculty members who participated in the study. The findings are then presented through the themes that emerged from the participants' interviews and describe their experiences transitioning from clinical practice to teaching in higher education. The chapter concludes with a summary that brings together the findings presented in Chapter 4.

Participant Demographics

The findings were drawn from interviews with 14 allied health educators who had between one and five years of teaching experience and described their experiences transitioning from clinical practice to teaching within allied health programs at community colleges. The findings revealed several interconnected patterns related to the transition from clinical practice to teaching, the development of teaching practices, professional identity, relationships with learners and colleagues, and participants' adaptation to the academic environment.

Participants represented a range of professional and educational backgrounds within allied health education, providing varied perspectives on the transition from clinical practice to teaching in community colleges. Their experiences included different levels of clinical and teaching experience as well as varied faculty responsibilities across didactic, laboratory, and clinical instructional settings. This diversity provided multiple perspectives through which the participants described their experiences of developing as teachers within the academic environment.

Table 4-1 presents the participants' demographic and professional characteristics, including age, gender, faculty role, years of clinical experience, and years of teaching

experience. Participants represented anesthesia technology, dental hygiene, dental assisting, surgical technology, surgical first assistant, and First Aid/CPR instructional contexts across six community colleges. Clinical experience ranged from 7 to 36 years, while teaching experience ranged from 1 to 5 years. Participant identifiers were represented by pseudonyms to protect confidentiality.

Table 4-1 Participant Demographic and Professional Characteristics

	Age	Gender	Faculty Role	Clinical Exp.	Teaching Exp.
P1	44	F	D	20	5
P2	67	M	D	27	4
P3	46	F	Cl	7	4
P4	48	F	D, L, Cl	15	5
P5	53	F	D, Cl	26	3
P6	58	M	D	25	4
P7	63	F	D, L, Cl	22	4
P8	52	F	D	21	4
P9	54	M	Cl	27	5
P10	33	F	Cl	9	2
P11	43	F	L, Cl	22	1
P12	41	F	D, L	14	1
P13	59	F	D, Cl	36	4
P14	54	F	L	10	2

Note. Participant identifiers (P) are pseudonyms used to protect confidentiality. Gender: M = Male; F = Female. Faculty role: D = Didactic; L = Laboratory; Cl = Clinical.

As shown in Table 4-1, the participants brought substantial clinical experience to their faculty roles, with teaching experience representing a more recent component of their professional backgrounds. The variation in clinical and teaching experience, allied health disciplines, and faculty responsibilities provided a range of perspectives on the transition from clinical practice to teaching. Although participants entered academia from different professional and instructional contexts, their experiences provided a broad basis for examining how clinicians developed and enacted their roles as teachers within higher education.

Findings

The findings were drawn from interviews with 14 allied health educators who had between one and five years of teaching experience within community college allied health programs. Participants described their experiences transitioning from clinical practice to faculty roles and developing their approaches to teaching within the academic environment. Six themes emerged from the analysis: (1) new faculty slowly embraced a professional identity as teachers rather than clinicians; (2) new faculty transformed their understanding of teaching through the limitations of clinical expertise; (3) new faculty expanded their teacher identity through a commitment to student learning and success; (4) new faculty developed innovative perspectives through academic collaboration and self-directed learning; (5) new faculty established their professional identity through academic and professional accountability; and (6) new faculty transformed their teaching practices through reflection and adaptation.

Theme 1: New Faculty Slowly Embraced a Professional Identity as Teachers Rather Than Clinicians

Participants described the transition from clinical practice to a faculty role as more than a change in employment. It involved developing a professional identity that incorporated the responsibilities of teaching while, for many, maintaining a strong connection to their clinical backgrounds. Although participants entered academia with established clinical expertise, their accounts reflected different experiences in recognizing and embracing the role of teacher. For some, this change involved uncertainty and self-doubt; for others, it developed through teaching experience, student relationships, and growing acceptance within the academic community.

Participants described differences in the responsibilities associated with clinical practice and academic teaching. Participant 1 explained, “In a clinical practice I am only responsible for

my actions and the safety of my patient. In the classroom, I am responsible for multiple people at once." Participant 10 described a similar distinction, explaining that clinical practice involved situations where "somebody's life is actually in your hand," whereas in the classroom, "you are helping to shape their future." These accounts reflected how participants began to understand that their professional responsibilities extended beyond individual clinical performance to the development of future healthcare professionals.

For some participants, identifying as a teacher was initially difficult. Participant 9 explained that he continued to see himself as a clinician because "it took me a long time to get out of my head that I'm an anesthesia tech helping out a college." Participant 12 similarly acknowledged the difficulty of describing a new professional identity, stating, "It's kind of awkward identifying as a teacher, I haven't figured that out yet. I still say that I'm just a technologist." These accounts illustrated that accepting a faculty position did not automatically change how participants viewed themselves professionally.

Other participants described a gradual expansion of their professional identities. Participant 5 explained, "I still strongly identify myself as a clinician and a clinical leader. But it's broadened my professional identity and shifted some of my focus towards student learning and their development." Participant 8 described a more direct change in professional identification, explaining that they now introduced themselves as dental hygiene faculty rather than solely as a clinician. Participant 11 similarly stated, "I describe myself as an educator." These accounts demonstrated that participants did not necessarily leave their clinical identities behind. Instead, the teacher role became an additional and increasingly recognized part of their professional identities.

The development of this identity also occurred through experience and recognition from others. Participant 6 explained that it took until the second or third year of teaching to begin feeling that they belonged in academia. Reflecting on student feedback, the participant recalled former students returning to express appreciation for what they had learned. The participant explained, “And that made me feel as though, well, maybe I do belong here. Maybe I am doing the right thing.” Participant 1 described a similar progression, explaining, “I think it took me at least a year to truly feel comfortable in the role.” She described having to consider not only teaching content but also students, curriculum, and administrative responsibilities before she could say, “this is my place now.” Participant 8 recalled that by the fall of the second year, “I got the swing of this. I got a little stride.” Together, these accounts illustrated how confidence and identification with the faculty role developed through accumulated experience and increasing familiarity with academic responsibilities.

However, participants did not experience this transition in the same way. Participant 10 described feeling that academia was in their heart from the beginning, while Participant 11 described feeling more confident in the role toward the end of the second semester. Participant 7, who continued practicing clinically while teaching, described reaching a greater sense of belonging around the third cohort, after several years of navigating the academic environment. These differences demonstrated that becoming a teacher was not a uniform or linear process. Participants developed their identities at different rates and, in some cases, continued to identify with both clinical and academic roles.

Taken together, participants' accounts demonstrated that embracing the role of teacher involved a gradual and varied development of professional identity. Clinical experience remained an important part of who participants were, while teaching responsibilities,

relationships with students and colleagues, and growing confidence contributed to an expanded understanding of their professional roles. For these participants, becoming a teacher was not simply the result of accepting a faculty position; it developed through the experiences and relationships that followed.

This theme addressed Research Question 1 by examining how participants described the evolution of their professional identities during the transition from clinical practice to academic roles. Their accounts illustrated how participants gradually began to recognize and embrace the responsibilities of being a teacher while maintaining connections to their clinical backgrounds. The findings demonstrated that this transition was not immediate or uniform but developed through experience, increased confidence, and growing identification with the academic role.

Theme 2: New Faculty Transformed Their Understanding of Teaching Through the Limitations of Clinical Expertise

Participants described learning that clinical expertise and teaching expertise were related but not interchangeable. Although they entered academia with substantial knowledge and experience in their clinical disciplines, many had little formal preparation in pedagogy, lesson planning, assessment, or the broader responsibilities of teaching. Their accounts reflected a learning process that involved practice, observation, experimentation, and, in some cases, seeking guidance from other educators.

The initial learning curve was evident in participants' descriptions of entering academia without fully understanding the educational responsibilities of the faculty role. Participant 2 explained, "I really didn't know much about" the education component of the program. He further described the absence of formal preparation, stating, "There was nothing that was formal." Participant 5 identified a different aspect of this challenge, explaining, "I did understand

of course the clinical content, but I had to figure out how to organize and communicate that, so it made sense to someone who was just learning." Participant 10 described the practical responsibilities as overwhelming, explaining, "You have to prepare the lectures, you have to study the lectures," in addition to creating tests, navigating testing systems, managing examinations, and maintaining the gradebook. These accounts demonstrated that clinical knowledge alone did not prepare participants for the instructional and administrative demands of teaching.

Participants also described learning how to teach through repeated practice and adjustment. Participant 3 explained, "I always tell new instructors, it takes about 3 times teaching the same course before you feel like you have it right." She described how the first attempt involved planning and hoping it worked, followed by identifying what needed to change. As she explained, "Then you learn what worked and what didn't work. You make the changes for the second time. Then adjust again." Participant 5 described a similar process, stating that she observed other educators and relied on "trial and error." These experiences showed how participants developed instructional approaches by evaluating their teaching and adjusting based on what they observed.

Another challenge involved translating familiar clinical knowledge into material that students could understand. Participant 12 described having to change the way she communicated information, explaining, "I must slow down. I must explain things that is second nature to me." She recognized that students encountering instruments, supplies, and clinical concepts for the first time needed more explanation than she had previously provided in practice. Participant 5 described a similar realization, explaining that students were "so green they don't understand" and that she had to organize and communicate clinical information in ways that supported their

learning. These accounts illustrated the adjustment from knowing how to perform clinical tasks to explaining the reasoning and concepts behind them.

Participants also identified responsibilities beyond classroom instruction that required new approaches and skills. Participant 7 explained, “I think time management was the biggest thing,” describing how balancing teaching, grading, student advising, and administrative responsibilities became difficult. The participant acknowledged, “I found myself falling behind sometimes in grading.” Participant 12 described the broader demands of teaching as including “lesson planning, the grading, and creating the assessments,” along with keeping students engaged and documenting their progress. These responsibilities represented additional demands that participants had not necessarily encountered in their previous clinical roles.

Taken together, participants’ accounts demonstrated that developing as a teacher required more than transferring clinical knowledge into a classroom. Participants had to learn how to organize instruction, explain familiar concepts to novice learners, assess student learning, manage academic responsibilities, and adjust their teaching through experience. Although their clinical backgrounds provided a foundation for instruction, participants described developing the knowledge and practices needed to teach as a distinct process.

This theme addressed Research Question 2 by examining how participants described developing instructional knowledge and skills during their transition from clinical practice into the academic environment.

Theme 3: New Faculty Expanded Their Teacher Identity Through a Commitment to Student Learning and Success

As participants developed their teaching practices, they increasingly described their responsibility in terms of supporting students as learners rather than simply delivering clinical or

academic content. Participants discussed individual circumstances, relationships, communication, empathy, and student engagement as important parts of their work. Their accounts reflected an expanding understanding of the faculty role that included recognizing the needs of the individual student and the circumstances that could affect learning.

Participant 1 described how the classroom provided opportunities to understand students in ways that were not always possible in clinical practice. She explained, “Whereas in the classroom, you have the time to consider all these external factors, and you have time to improve upon any distractions, any obstacles that may affect their learning.” She further explained that spending more time with students allowed her to “help them overcome those obstacles so that they can achieve their goal.” Participant 9 also emphasized the human element of teaching, describing the importance of recognizing when students were experiencing outside stressors while balancing school and other responsibilities. These accounts demonstrated that participants increasingly considered circumstances beyond academic performance when supporting student learning.

Relationships were another important part of participants’ approaches to teaching. Participant 3 connected her clinical experience directly to her relationships with students, explaining, “In a dental practice you build relationships with patients to help them understand their oral health and make changes. It is the same with students. You build positive relationships with them to help them understand and be successful.” Her description illustrated how relationship-building became part of her approach to helping students learn. Rather than viewing instruction as simply delivering information, she emphasized developing relationships that supported student understanding and success.

Several participants connected these relationships to a personal responsibility for student learning. Participant 6 explained, “If a student failed, I feel as though I failed the student.” He also described becoming more understanding when students experienced difficulties, recognizing that circumstances beyond the classroom could influence their behavior and performance. His account reflected a view of teaching in which student struggles prompted the instructor to consider whether additional understanding or support was needed.

Participants also described recognizing differences in how students learned and adjusting their instructional approaches accordingly. Participant 10 explained, “Everyone learns differently,” and acknowledged that a teaching method that felt comfortable to the instructor might not help students comprehend the content. Participant 8 similarly described how working with a student with a learning disability prompted her to explore different instructional modalities and provide multiple ways for students to engage with the same material. Participant 12 described the importance of creating a classroom environment where students felt comfortable participating and learning, rather than relying on fear or intimidation. These experiences demonstrated how participants increasingly recognized the need to adapt their teaching to the students in front of them.

Taken together, participants’ accounts demonstrated that their understanding of teaching extended beyond delivering content and evaluating performance. They described building relationships, recognizing individual circumstances, adapting instruction, and taking an active interest in student progress. Supporting student success became an important part of how they understood and carried out their responsibilities as educators.

This theme addressed Research Question 1 by examining how participants described the expansion of their professional responsibilities as they moved into academic roles. Their

accounts reflected a growing recognition that being a teacher involved not only sharing clinical knowledge but also understanding, supporting, and advocating for students as learners.

Theme 4: New Faculty Developed Innovative Perspectives Through Academic Collaboration and Self-Directed Learning

Participants described learning to function within an academic environment that required knowledge and skills extending beyond their previous clinical experience. They encountered unfamiliar institutional expectations, academic processes, technology, curriculum responsibilities, and administrative procedures. Their accounts demonstrated that navigating these responsibilities involved different forms of support, including mentorship, collaboration with colleagues, observation, and independent learning. However, the availability and structure of that support varied among participants.

For some participants, mentorship and administrative support played an important role in their transition. Participant 1 described how encouragement from an experienced colleague helped ease her initial nervousness about teaching. Reflecting on that support, she explained, “I definitely had really good mentor because I remember, when I initially started and I was really nervous and he was telling me, no, you'll do great, you'll be fine.” She added, “So that really gave me confidence.” Participant 2 also described relying on experienced faculty, explaining, “I had a lot of really good peers and mentors and faculty that I really relied on to help me with that particular role.” He described sharing lectures and asking colleagues to review his work before moving forward. These accounts illustrated how guidance from experienced educators helped participants become more comfortable with unfamiliar academic responsibilities.

Other participants relied on informal collaboration and their own initiative to find answers. Participant 6 described the value of drawing on the experience of colleagues,

explaining, “You don't reinvent the wheel, basically, just go and ask. Someone's bound to have run into the situation or problem.” He further explained that he continued to rely on people at the college to provide guidance. Participant 8 similarly described seeking assistance from colleagues while also relying on independent learning. She explained that her transition involved “colleagues and lots of lots of reading and trying to understand, okay, what can I do better? How can I become a better instructor?” She also described using instructional videos and conversations with others to develop her teaching practices. These accounts demonstrated that support did not always come through a formal mentoring program; participants often developed their own networks and sought information when they encountered unfamiliar situations.

However, not all participants experienced the same level of support. Participant 4 directly acknowledged, “Unfortunately, no, I did not have that,” when discussing whether she had received mentorship during her transition. She explained, “I am not a person who sits and simmers in my questions, so I always sought out the director, hey, I'm having this issue, I need guidance on this.” When discussing the absence of a mentor, she described having to teach herself how to function in the faculty role. Her experience highlighted the difference between having an established support structure and having to independently identify people and resources who could assistance.

Participants also encountered challenges learning the technological and administrative systems required of faculty members. Participant 8 described difficulty navigating Blackboard and managing digital gradebooks, explaining that she frequently needed assistance with these responsibilities. Participant 11 similarly described relying on an experienced colleague when navigating Blackboard and other unfamiliar academic processes. These experiences

demonstrated that even routine institutional systems required adjustment for individuals whose previous professional responsibilities had not included managing these academic platforms.

Across participants' accounts, navigating the academic environment involved more than learning classroom responsibilities. Participants had to become familiar with institutional processes, identify resources, develop professional relationships, and seek guidance when unfamiliar situations arose. While some benefited from consistent mentorship and established support, others relied more heavily on informal collaboration and self-directed learning. Their experiences demonstrated how access to guidance and the ability to seek out support contributed to their adjustment to the academic environment.

This theme addressed Research Question 2 by examining how participants described learning to navigate the academic environment through mentorship, collaboration, observation, and self-directed learning. Their accounts illustrated how support systems and independent efforts contributed to developing the knowledge and confidence needed to function within their faculty roles.

Theme 5: New Faculty Established Their Professional Identity Through Academic and Professional Accountability

Participants described discovering that the responsibilities associated with teaching extended beyond knowing clinical content and demonstrating clinical skills. As faculty members, they became responsible for student evaluation, academic standards, curriculum expectations, professional conduct, and, in some disciplines, maintaining alignment with accreditation and professional requirements. Their accounts demonstrated that clinical experience remained valuable, but academic responsibilities required an additional level of accountability.

Participant 2 described encountering accreditation standards and curriculum requirements that were unfamiliar to him when he entered academia. He explained, “In education, obviously different from clinical, you have accreditation standards of which I never really knew nothing about.” He also described the importance of ensuring that his instruction met those expectations, stating, “Because again, you have accreditation standards and I want to make sure that we're following all of those standards.” His account illustrated how faculty responsibilities extended beyond delivering course content to ensuring that instruction aligned with program and professional requirements.

Participants also described the challenge of balancing multiple responsibilities while maintaining consistency in their academic work. Participant 1 explained that the faculty role required attention to more than teaching content, including “factoring the students, factoring the curriculum of the program, factoring the administrative part of it, what administration required from me.” Participant 7 similarly described the demands of balancing teaching, grading, student advising, and administrative tasks. Reflecting on these responsibilities, the participant stated, “I think time management was the biggest thing,” and acknowledged, “I found myself falling behind sometimes in grading.” These accounts demonstrated how faculty members had to manage competing responsibilities while maintaining expectations for student evaluation and program requirements.

Maintaining consistent academic standards also required participants to reconsider practices they had become accustomed to in clinical settings. Participant 4 described the importance of learning how to calibrate grading systems and follow institutional expectations, explaining that she had not received adequate training in these areas. She recalled, “Kind of just thrown into it headfirst,” when describing the process of learning the institution's expectations.

Participant 11 also described adjusting to the standards of an academic environment, explaining that private practice allowed more flexibility, whereas teaching required adherence to established procedures. These experiences illustrated that faculty members could not always rely on the practices they had developed in clinical settings; they also had to ensure that students were being taught according to established academic and professional expectations.

Academic integrity represented another dimension of this responsibility. Participant 12 described concerns about student cheating and the need to adjust examination practices to protect the integrity of student assessments. The participant's account illustrated that faculty accountability included ensuring that examinations accurately reflected student knowledge and that academic expectations were maintained. Assessment was not simply a matter of assigning grades; it also involved protecting the fairness and credibility of the evaluation process.

Taken together, participants' accounts demonstrated that becoming a faculty member involved accepting responsibilities that extended beyond clinical expertise and classroom instruction. Participants had to maintain academic and professional standards, manage competing responsibilities, evaluate students consistently, and ensure that their instruction aligned with program expectations. Clinical experience remained an important foundation, but faculty members also had to recognize and uphold the accountability associated with preparing students for professional practice.

This theme addressed Research Question 1 by examining how participants described the expansion of their professional responsibilities as they transitioned into academic roles. Their accounts reflected a growing recognition that being a teacher involved accountability for instruction, assessment, curriculum, academic standards, and the professional preparation of students.

Theme 6: New Faculty Transformed Their Teaching Practices Through Reflection and Adaptation

Participants described teaching as an evolving practice that changed as they gained experience and reflected on their interactions with students. Rather than maintaining the same instructional approaches they used when they first entered academia, participants described evaluating student responses, considering feedback, recognizing areas for improvement, and modifying their teaching. Reflection and adaptation became important parts of their continued development as teachers.

Student feedback provided one opportunity for participants to evaluate their instructional approaches. Participant 1 identified student feedback as one of the most influential experiences in her development as a faculty member. She explained, “The biggest experience I think is the student feedback. Really hearing their criticism, which was mainly positive.” She described using that feedback to make changes to her assessments, explaining, “Based on the feedback, I actually implemented some changes.” She specifically recalled revising examination questions when she recognized that students interpreted certain questions differently than she intended. Her experience demonstrated how feedback prompted her to reconsider instructional materials and adjust improve student understanding.

For Participant 6, reflection involved reconsidering who was responsible when students struggled to understand course material. He explained, “In the beginning, it was like, I'm going to put down the information and give the students the answers for it. And if they don't grasp or understand or utilize tools and things that are available to pass and understand the subject matter, then that's totally on them.” Over time, his perspective changed. He explained, “I believe that something I didn't do, or I didn't convey the message to them the way they could receive it.” This

change illustrated how experience prompted him to reconsider his instructional responsibility and look more closely at what he could do differently when students had trouble.

Repeated teaching experiences also provided opportunities for participants to evaluate and refine their instructional approaches. Participant 3 explained, “I always tell new instructors, it takes about 3 times teaching the same course before you feel like you have it right.” She described using each course offering to identify what worked and what needed adjustment. As she explained, “Then you learn what worked and what didn't work. You make the changes for the second time. Then adjust again.” She also described updating lectures, removing ineffective quiz questions, and adding more interactive activities. Her account demonstrated how reflection translated into specific changes in instructional practice.

Other participants described changing how they guided students through the learning process. Participant 5 explained that her clinical approach initially involved assessing a situation, planning, and completing the necessary care. As a faculty member, however, she recognized the need to slow down and explain the reasoning behind clinical decisions. She described asking students questions so they could understand the material and arrive at solutions independently rather than simply being told what to do. Participant 11 also described moving away from providing students with direct answers and toward prompting them to reach conclusions independently. These experiences illustrated how participants reconsidered familiar approaches and developed instructional strategies that encouraged student thinking and independence.

Participants also recognized that their own learning continued through interactions with students. Participant 10 described researching information alongside students when questions arose that she could not immediately answer. Rather than viewing those situations as limitations, she used them as opportunities to explore the material and support student learning. Participant 9

similarly described adjusting his communication when he recognized that students from different cultural and language backgrounds did not always understand his pace or expressions. These accounts demonstrated that participants continued to adapt their teaching in response to the needs and experiences of their students.

Taken together, participants' accounts demonstrated that developing as a teacher involved an ongoing process of evaluating instructional approaches, considering feedback, and adjusting. Participants learned from repeated teaching experiences, student responses, and their own recognition of areas that needed improvement. Their experiences showed that teaching development did not end once they became comfortable in the faculty role; rather, reflection and adaptation remained part of how they continued to develop as educators.

This theme addressed Research Question 2 by examining how participants described using experience, feedback, and reflection to evaluate their instructional approaches, recognize areas for improvement, and make changes to their teaching practices.

Chapter Summary

Chapter 4 presented the findings from interviews with 14 allied health educators who described their experiences transitioning from clinical practice to teaching within community college settings. Six themes emerged from the analysis, with three themes primarily addressing each research question. Themes 1, 3, and 5 addressed Research Question 1 by illustrating how participants' professional identities evolved as they transitioned from clinicians to educators. Collectively, these findings reflected the development of teacher identity through an expanding understanding of professional roles, a growing commitment to student learning and success, and an increased recognition of the academic and professional responsibilities associated with being an educator.

Themes 2, 4, and 6 addressed Research Question 2 by examining the transformative learning processes participants experienced as they developed into educators. These findings demonstrated how participants encountered challenges to their existing knowledge and assumptions, developed new perspectives through mentorship, collaboration, and self-directed learning, and transformed their teaching practices through reflection and experience. Together, these themes illustrated how participants reconsidered their understanding of teaching and incorporated new perspectives into their professional practices.

Chapter 5 - Discussion

Chapter 5 discusses what the findings reveal about the transition from clinician to educator among early-career allied health faculty in community colleges. The chapter connects the findings from Chapter 4 to the study's research questions, conceptual framework, and relevant literature. It also examines the implications of the findings for allied health education, offers recommendations for practice and future research, and considers how the study contributes to a better understanding of the challenges and experiences clinicians face as they become teachers.

Purpose of the Study

The purpose of this study was to explore how clinicians experienced and made meaning of their transition from clinical practice to community college faculty roles, including how they interpreted their evolving professional roles as educators. The study focused specifically on early-career allied health faculty who had transitioned from clinical practice into academic roles within community colleges.

Discussion of Findings Related to the Research Questions

The findings of this study provide insight into how early-career allied health faculty experience the transition from clinical practice to academic roles within community colleges. This transition involves more than learning teaching skills; it is an ongoing process of developing a professional identity, adapting to new responsibilities, reflecting on experiences, and finding meaning in the role of a teacher. Clinical expertise provides an important foundation for teaching, but faculty must also develop new approaches to instruction, relationships with students, and the responsibilities associated with working in an academic environment. The following discussion examines the study's findings in relation to the two research questions, the

theoretical frameworks, and relevant literature on teacher identity development and the transition from clinician to educator.

Research Question One

This question explored how clinicians understood and experienced changes in their professional identities, responsibilities, and relationships with students as they transitioned into academic roles. The findings demonstrated that becoming an educator involved more than applying clinical expertise in a classroom. Participants described developing a professional identity as teachers, accepting greater responsibility for student learning and development, and recognizing the academic and professional expectations associated with preparing future healthcare practitioners. Three themes addressed this research question: theme 1, new faculty slowly embraced a professional identity as teachers rather than clinicians; theme 3, new faculty expanded their teacher identity through a commitment to student learning and success; and theme 5, new faculty established their professional identity through academic and professional accountability.

Theme 1 demonstrated how participants' professional identities evolved as they became more familiar with the expectations and responsibilities of teaching. Although participants entered academia with established clinical identities, they did not necessarily view themselves as educators immediately. Participant 14 described the adjustment by explaining, “I went from being an experienced preceptor to an unexperienced faculty member.” Later, when describing how her professional identity had developed, she stated, “I see myself as a teacher.” These statements illustrate the movement from an established clinical and preceptor identity toward recognition of oneself as an educator. Participants' experiences demonstrated that teacher identity

developed through increasing familiarity with the faculty role and a growing recognition of themselves as members of the academic profession.

Theme 3 demonstrated that the development of teacher identity also involved an expanding understanding of responsibility for student learning and success. Participants increasingly recognized that their roles extended beyond delivering information or demonstrating clinical procedures. They described the importance of understanding individual student needs, developing supportive relationships, and helping students become competent future practitioners. Participant 4 described the complexity of this responsibility in the clinical learning environment, explaining, “Clinically, you're responsible for the student's actions. And you are also responsible for the patient that is in that chair, too?” Her account illustrated how the educator role involved balancing responsibility for patient safety with the responsibility of guiding students as they developed their clinical abilities. These experiences reflected how participants' understanding of being an educator became increasingly connected to their responsibility for student development and success.

Theme 5 further demonstrated how participants' teacher identities were shaped by their recognition and acceptance of academic and professional accountability. Faculty members became responsible for maintaining academic standards, evaluating student performance, meeting curriculum expectations, and ensuring that students were adequately prepared for professional practice. These responsibilities required participants to recognize that clinical expertise, while essential, did not replace the expectations associated with academic instruction and professional preparation. Their accounts reflected an expanded understanding of what it meant to function as an educator, including the professional obligations associated with teaching within an academic institution.

The findings across these three themes demonstrated that the transition from clinical practice to teaching involved the development and expansion of professional identity. Participants retained the clinical expertise that initially prepared them for their academic positions, but their understanding of their professional roles expanded to include educating, supporting, evaluating, and preparing future healthcare practitioners. Their experiences illustrated that teacher identity developed not simply through assuming a faculty position, but through recognizing and accepting the responsibilities, relationships, and professional expectations associated with being an educator. This evolution reflected a broader understanding of themselves as healthcare professionals whose work extended beyond clinical practice to the education and preparation of future practitioners.

Research Question Two

This question explored how faculty members described the learning processes that influenced their transition from clinical practice to the academic environment. Viewed through Mezirow's (2000) transformative learning theory, participants' accounts reflected experiences in which established clinical knowledge and assumptions about professional practice were challenged, prompting them to reconsider how they understood teaching, student learning, and their responsibilities as educators. Three themes addressed this research question: theme 2, new faculty transformed their understanding of teaching through the limitations of clinical expertise; theme 4, new faculty developed innovative perspectives through academic collaboration and self-directed learning; and theme 6, new faculty transformed their teaching practices through reflection and adaptation. These themes illustrated how participants encountered experiences that challenged existing assumptions, developed new perspectives through interactions and independent learning, and incorporated revised understandings into their teaching practices.

Theme 2 revealed experiences that challenged participants' assumptions about the transferability of clinical expertise. Participants entered academia with established professional knowledge and years of clinical experience, but many discovered that knowing how to perform a procedure or make a clinical decision did not necessarily prepare them to explain that knowledge to novice learners. This realization required participants to reconsider how they communicated information and approached instruction. Participant 12 described this adjustment by explaining, “I must slow down. I must explain things that is second nature to me.” This experience reflected more than the acquisition of an instructional technique; it demonstrated a reconsideration of how knowledge developed through clinical experience could be communicated to individuals who had not yet acquired that expertise. In relation to Mezirow's theory, these unfamiliar instructional demands represented experiences that challenged participants' existing frames of reference and prompted them to reconsider what it meant to teach.

Theme 4 demonstrated how participants developed new perspectives as they learned to function within an unfamiliar academic environment. As they encountered institutional expectations, unfamiliar processes, and responsibilities outside their clinical experience, participants sought guidance through mentorship, collaboration, observation, and self-directed learning. These interactions provided opportunities to examine different approaches, learn from the experiences of others, and develop new understandings of their faculty responsibilities. However, participants did not have equal access to formal support. Some benefited from established mentoring relationships, while others relied on personal initiative and informal professional networks. Participant 5's experience was particularly illustrative. The absence of consistent onboarding and a designated mentor required the participant to find ways to understand academic responsibilities independently, with occasional assistance from a colleague.

Reflecting on this experience, the participant recognized the importance of structured onboarding, designated mentors, clear expectations, and opportunities to observe experienced instructors. This finding demonstrated that participants encountered different institutional conditions and developed different ways of responding to the demands of the academic environment. Participant 6 described the value of seeking assistance from colleagues, explaining, "You don't reinvent the wheel, basically, just go and ask. Someone's bound to have run into the situation or problem." His account illustrated how collaboration provided opportunities to learn from others and develop strategies for addressing unfamiliar academic responsibilities. In relation to Transformative Learning Theory, these experiences reflected the exploration of new perspectives and approaches as participants learned to function within their faculty roles.

Theme 6 provided particularly strong evidence of critical reflection and the transformation of teaching practices. Participants described evaluating their instructional decisions, considering student feedback, and changing practices when they recognized that their original approaches were not producing the desired learning outcomes. Participant 6 provided a clear example of this change in perspective. Reflecting on his early teaching experiences, he explained, "In the beginning, it was like, I'm going to put down the information and give the students the answers for it. And if they don't grasp or understand or utilize tools and things that are available to pass and understand the subject matter, then that's totally on them." He later reconsidered that assumption, explaining, "I believe that something I didn't do, or I didn't convey the message to them the way they could receive it." His account demonstrated a shift from viewing student difficulty primarily as the student's responsibility to examining his own instructional decisions and considering what he could change to support learning. This movement from an established assumption toward a more reflective understanding of teaching

closely aligns with Mezirow's emphasis on critical reflection and the revision of previously held perspectives. Participant 3 also described how repeated teaching experiences provided opportunities to evaluate and modify instructional approaches, explaining, “I always tell new instructors, it takes about 3 times teaching the same course before you feel like you have it right.” Her experience illustrated how reflection and subsequent adjustments became part of her continued development as an educator.

The findings addressing Research Question 2 demonstrated that participants experienced the transition into academic teaching as a process of challenging established assumptions, developing new perspectives, and transforming their professional practices. Theme 2 illustrated how participants reconsidered the relationship between clinical expertise and teaching. Theme 4 demonstrated how academic collaboration and self-directed learning helped participants explore new approaches to their academic responsibilities. Theme 6 revealed how critical reflection contributed to changes in how participants understood and approached instruction. These findings align with Mezirow's (2000) transformative learning theory, particularly the role of challenging experiences, critical reflection, exploration of new perspectives, and the application of revised understandings. Participants' accounts did not suggest that transformation occurred through a uniform or strictly linear sequence. Rather, their experiences reflected different pathways through which they reconsidered existing assumptions, developed new understandings, and incorporated those understandings into their work as educators.

Discussion of Findings Related to Conceptual Framework

The findings provided evidence of several processes consistent with Mezirow’s (2000) transformative learning theory. Participants described experiences in which entering the academic environment challenged assumptions and expectations developed through years of

clinical practice. These experiences prompted them to reconsider what it meant to teach, how students developed understanding, and how they would function within an academic environment. Mezirow's theory emphasizes that transformative learning can occur when individuals encounter experiences that challenge established frames of reference and engage in reflection that contributes to revised perspectives. The findings suggest that participants experienced elements of this process as they recognized limitations in their previous preparation, sought new knowledge and support, and reconsidered their approaches to teaching.

Theme 2: new faculty transformed their understanding of teaching through the limitations of clinical expertise provided evidence of participants reconsidering assumptions about professional expertise. Participants entered academia with substantial clinical knowledge and experience, but many discovered that clinical competence did not automatically prepare them to teach. They had to reconsider how knowledge was organized, communicated, and facilitated for students. Moving from performing a clinical task to explaining the knowledge and reasoning behind it required participants to recognize the differences between clinical practice and academic instruction. Participant 12 described this adjustment by explaining, "I must slow down. I must explain things that is second nature to me." This experience illustrated how participants began questioning assumptions about what students should already know and recognized that effective teaching required a different approach to communicating professional knowledge. In relation to Mezirow's theory, these experiences represented challenges to established frames of reference and prompted participants to reconsider the relationship between knowing a subject and teaching it.

Theme 4: new faculty developed innovative perspectives through academic collaboration and self-directed learning extended this interpretation by demonstrating how participants

developed new ways of understanding and functioning within an unfamiliar academic environment. Participants described seeking guidance from mentors, colleagues, deans, and other faculty members while learning institutional processes, academic expectations, and unfamiliar systems. However, the availability and consistency of support varied. Some participants benefited from established mentoring relationships and accessible colleagues, while others experienced limited formal onboarding and relied more heavily on observation, independent learning, and asking questions. Participant 5's experience illustrated the challenges associated with limited onboarding and the need to develop an understanding of academic responsibilities through independent effort and available colleague support. The participant also recognized the value of structured onboarding, designated mentors, clear expectations, and opportunities to observe experienced instructors. This finding adds an important dimension to the interpretation of transformative learning because participants did not encounter the same institutional conditions or have equal access to support. Instead, they developed different ways of responding to the demands of the academic environment. Participant 6 described the value of seeking assistance from colleagues, explaining, "You don't reinvent the wheel, basically, just go and ask. Someone's bound to have run into the same or similar situation." His account illustrated how collaboration provided opportunities to learn from others and develop strategies for addressing unfamiliar academic responsibilities. These experiences reflected the exploration of new approaches and perspectives as participants learned to function within their faculty roles. Although collaboration and self-directed learning did not necessarily represent transformation on their own, they provided opportunities for participants to reconsider how they approached their academic responsibilities.

Theme 6: new faculty transformed their teaching practices through reflection and adaptation provided further evidence of the reflective processes described by Mezirow. Participants described evaluating their teaching experiences, identifying what worked and what did not, considering student responses, and modifying their instructional approaches. Rather than assuming their initial teaching methods were effective, participants increasingly recognized the need to examine their practices and adjust. Participant 3 described how repeated experience teaching the same course allowed her to identify areas for improvement, explaining, “I always tell new instructors, it takes about 3 times teaching the same course before you feel like you have it right.” Her account illustrated how repeated teaching experiences provided opportunities to evaluate instructional decisions and refine approaches over time. More importantly, some participants described changes that extended beyond modifying instructional techniques. Participant 6, for example, reconsidered his belief that students were primarily responsible when they failed to understand course material and began examining what he could change as an instructor. This reconsideration is particularly consistent with Mezirow’s emphasis on critical reflection because it involved examining an established assumption and developing a different understanding of one's responsibility as an educator.

The findings also provide insight into the nature of transformative learning during the transition from clinical practice to academia. Participants did not describe transformation as a single event that occurred upon entering an academic position. Instead, their accounts reflected learning and adjustment that developed through unfamiliar responsibilities, challenges, interactions with others, and repeated teaching experiences. Recognizing that clinical expertise did not automatically translate into teaching ability, learning to navigate academic expectations, and reconsidering instructional practices represented related but distinct experiences. These

findings suggest that participants' development as educators involved recognizing limitations in their previous preparation, exploring new approaches, and modifying their practices as they gained experience.

The findings further indicate that participants did not experience every element of Mezirow's 10-phase process in the same manner. Participants described different starting points, challenges, sources of support, and experiences of adjustment. Some accounts included clear examples of assumptions being challenged and subsequent reflection, while others emphasized learning through observation, collaboration, independent effort, and repeated teaching experiences. Therefore, the findings should not be interpreted as evidence that every participant progressed sequentially through all ten phases of transformative learning. Rather, participants' accounts demonstrated elements of the reflective and perspective-changing processes described by Mezirow as they encountered and responded to the demands of the academic environment.

Overall, the findings demonstrate that the transition from clinical practice to academia created opportunities for participants to question assumptions developed through clinical experience, recognize areas where additional knowledge was needed, seek guidance and resources, and reflect on and modify their teaching practices. Their descriptions of recognizing the limitations of clinical expertise, developing new perspectives within the academic environment, and changing instructional practices through reflection provide evidence of transformative learning processes within the clinician-to-faculty transition. Becoming an educator involved more than transferring existing professional knowledge into a classroom; it required participants to reconsider how they understood teaching and develop new ways of approaching their responsibilities as faculty members.

Discussion of Findings Related to the Literature

The findings of this study support existing literature describing the transition from clinical practice to academic teaching as a significant professional adjustment. Participants entered faculty roles with substantial clinical expertise but often had limited preparation in lesson planning, assessment, grading, technology, and other academic responsibilities. This finding is consistent with Myers (2024), who described the tension between established clinical expertise and developing pedagogical competence among clinicians entering teaching. Similarly, Mesimer (2024) identified role ambiguity and increased workload associated with academic responsibilities as challenges for new faculty. These studies help explain why clinical expertise alone may not fully prepare clinicians for the expectations of teaching. The present study further illustrates how early-career faculty learned to organize and communicate familiar clinical knowledge in ways that supported student learning.

The findings also align with literature examining professional identity development during the transition into academia. Myers (2024) described how early-career faculty initially identified primarily as clinicians before gradually developing a stronger sense of themselves as educators. This pattern was evident in the present study, as participants described becoming more comfortable with the teacher role through repeated teaching experiences, feedback, and increased familiarity with academic responsibilities. Beauchamp and Thomas (2009) similarly conceptualized teacher identity as dynamic and shaped by professional interactions and context. Their framework supports the understanding that becoming a teacher is not an immediate change associated with accepting a faculty position, but an ongoing process shaped by experience and relationships. The present study extends this understanding by examining how early-career allied health faculty developed their professional identities within community college settings.

Institutional support and faculty development were also important points of connection between the findings and existing research. Participants described differences in the preparation and guidance available to them, with some receiving mentorship and others relying on observation, independent learning, and trial and error. This finding is consistent with Cobourne (2022), who emphasized the role of mentoring in faculty engagement and career satisfaction, and Smith (2022), who described the challenges new faculty faced when structured training was limited. Elliott and Oliver (2016) also connected professional development in community colleges with improvements in teaching strategies and student achievement. The literature and present findings suggest that support for new faculty should extend beyond initial orientation. Ongoing mentorship and practical professional development may help clinicians develop the instructional skills and confidence needed to fulfill their academic responsibilities.

The findings also highlighted the importance of relationships with students and the development of student-centered teaching practices. Participants described learning to adjust instruction, recognize differences in student learning needs, and take greater responsibility for supporting student progress. These findings complement Gonzalez-Bosch (2024), who emphasized cultural competence and student-centered strategies in community college faculty development, and Hyson et al. (2021), who found that professional development could influence classroom approaches, student engagement, and active learning. The present study adds to this literature by showing how early-career allied health faculty described developing these practices as they gained teaching experience. Rather than relying solely on their knowledge of clinical content, participants learned to consider how students understood and applied that content.

Another connection with the literature involved the institutional and professional responsibilities that accompanied the faculty role. Participants described learning to navigate

academic systems, curriculum expectations, assessment requirements, accreditation standards, and administrative duties. Mesimer (2024) identified expanded responsibilities and role ambiguity as challenges during the transition, while the American Association of Community Colleges (AACC, 2022) outlined competencies that extend beyond subject-matter expertise to include instructional strategies, student success, and an understanding of community college culture. The findings of this study illustrate how these broader expectations became part of participants' day-to-day work as teachers. They also demonstrate that developing as an educator involves learning to function within the institutional environment, not simply learning how to deliver instruction.

The study extends the existing literature by focusing on early-career faculty across multiple allied health disciplines in community colleges. The literature reviewed for this study included research on faculty development, professional identity, mentoring, and transitions into teaching; however, much of the transition literature discussed in Chapter 2 focused on nursing or other educational settings. The present study included faculty from anesthesia technology, dental hygiene, dental assisting, surgical technology, surgical first assisting, and First Aid/CPR instructional contexts. This broader disciplinary perspective provides insight into how clinicians from different allied health fields experience the transition into academic roles within community colleges. It also highlights the value of examining faculty development within the specific context of allied health education rather than if findings from other disciplines fully capture these experiences.

Finally, the findings are consistent with research describing professional development as an ongoing process rather than a single event. Cranton and Kasl (2012) highlighted the role of collaborative discourse in challenging teaching assumptions, while Laros et al. (2017) described

perspective transformation as a process that may occur gradually through sustained reflection. In the present study, participants described learning from experience, reconsidering instructional approaches, and adjusting based on how students responded. These findings reinforce the view that developing as a teacher continues beyond initial preparation and the first stages of employment. They also add a practical dimension to the literature by illustrating how reflection and adaptation became part of participants' efforts to improve their teaching.

Overall, the findings support existing research on the challenges of transitioning from clinical practice to teaching, the development of professional identity, and the importance of institutional support. They extend this work by providing insight into the experiences of early-career faculty across multiple allied health disciplines in community colleges. The findings suggest that supporting clinicians as they become teachers requires attention to instructional preparation, student-centered practice, institutional responsibilities, mentorship, and opportunities for continued reflection and professional development.

Implications for Practice

The findings of this study suggest several ways community colleges and allied health programs can better support clinicians transitioning into faculty roles. Participants entered academia with substantial clinical expertise but described the need to develop additional skills and understanding related to instruction, student learning, academic responsibilities, and the expectations of the faculty role. Their experiences suggest that supporting this transition requires more than recognizing clinical experience as preparation for teaching. Institutions must provide opportunities for clinicians to develop the knowledge, skills, and confidence needed to become effective teachers.

First, community colleges and allied health programs should provide practical faculty development that addresses the academic responsibilities new faculty encounter. Participants described learning to navigate lesson planning, assessment, grading, curriculum expectations, accreditation standards, academic technology, and administrative procedures. For example, participants discussed the challenge of organizing clinical knowledge for students who were unfamiliar with the subject matter, learning academic assessment processes, and managing responsibilities such as grading and course preparation. These findings point to the need for faculty development that addresses the actual work of teaching rather than relying solely on general institutional orientation. Workshops, instructional demonstrations, training in assessment and course development, and opportunities to observe experienced faculty could help clinicians develop the skills necessary to manage their academic responsibilities.

Second, institutions should establish designated mentorship opportunities and provide continued access to experienced faculty and administrators. Participants described different levels of support during their transition into teaching. Some benefited from mentors and colleagues who provided guidance, reassurance, and assistance with unfamiliar academic responsibilities. Others described limited formal mentoring and relied on their own initiative to seek help when questions or challenges arose. Participant 6 emphasized the value of collaboration, explaining, “You don't reinvent the wheel, basically, just go and ask. Someone's bound to have run into the same or similar situation.” This finding illustrates the value of making professional guidance accessible rather than expecting new faculty to independently navigate unfamiliar responsibilities. Designated mentors, regular opportunities for discussion, peer collaboration, and classroom observation could provide new faculty with consistent support as they develop their teaching practices and become more comfortable in their academic roles.

Third, faculty development should address the differences between clinical expertise and instructional competence. Participants described discovering that knowing how to perform a clinical procedure did not automatically prepare them to explain the underlying knowledge, reasoning, and skills to students. They had to learn to organize content, adjust their communication, recognize differences in student learning needs, and evaluate whether students understood the material. Participant 12 captured this adjustment by explaining, “I must slow down. I must explain things that is second nature to me.” This finding suggests that professional development should provide opportunities for clinicians to practice instructional strategies, receive feedback, and reflect on their teaching. Consistent with Beauchamp and Thomas’s (2009) conceptualization of teacher identity and Mezirow’s Transformative Learning Theory, these opportunities can support the ongoing development of faculty members' understanding of themselves as teachers and encourage them to reconsider and adapt established approaches to professional practice.

Finally, allied health programs should incorporate reflection and continuous improvement into faculty development. Participants described adjusting their teaching practices through repeated experience, student feedback, and reflection on instructional outcomes. Some reconsidered their initial approaches after recognizing that students were not learning as expected, while others modified course materials, explanations, and instructional strategies over time. These experiences suggest that faculty development should not end after initial training or orientation. Regular teaching evaluations, peer observations, opportunities to discuss instructional challenges, and structured reflection on student learning could help faculty identify areas for improvement and make informed adjustments to their teaching. Creating an

environment in which new faculty can discuss challenges and learn from experience may also help normalize the adjustment associated with transitioning from clinical practice to academia.

These implications reinforce the importance of intentional institutional support as clinicians develop into teachers. The findings indicate that effective preparation involves developing instructional skills, understanding academic responsibilities, accessing mentorship and collaboration, and continually reflecting on teaching practices. Community colleges and allied health programs can use these findings to strengthen faculty development practices and create an environment in which early-career faculty are supported not only in assuming academic positions but also in developing and sustaining their professional identities as educators.

Recommendations for Future Research

The findings of this study identify several areas for future research. One important area is the transition from clinician to clinical preceptor. Many allied health clinicians have opportunities to guide and teach students and colleagues in clinical settings before accepting formal faculty positions. However, not all clinicians choose to become preceptors, even when they have substantial clinical experience. This raises important questions about what motivates some clinicians to assume responsibility for teaching and evaluating learners while others remain focused primarily on their clinical roles. Future research should examine the factors that influence clinicians' decisions to become preceptors, including personal motivation, professional expectations, institutional encouragement, confidence, and perceptions of responsibility for developing future practitioners. Researchers could also explore whether clinicians experience a shift in their professional identity when they move from providing patient care to assuming responsibility for the learning and development of others. Understanding this earlier transition

may provide insight into when teacher identity begins to develop and whether the preceptor experience serves as a foundation for the later transition into formal academic teaching.

Future research could also build on the present study using a mixed-methods design. The qualitative interviews captured the complexity of participants' experiences, including changes in confidence, identity, teaching practices, relationships, and perceptions of their academic roles. However, a quantitative survey could provide additional information about faculty preparedness, satisfaction with the transition, confidence in teaching, institutional support, and identification with the teacher role. Combining these approaches could provide a more comprehensive understanding of the clinician-to-educator transition.

These recommendations provide opportunities to better understand how clinicians begin to assume responsibility for educating others and how their experiences, preparation, and professional identities develop as they move into academic teaching. Further examination of the clinician-to-preceptor transition may help explain what motivates clinicians to become educators and how the development of teacher identity may begin before they enter formal faculty positions.

Conclusion

The findings of this study lead to a conclusion that extends beyond the experiences of the 14 allied health educators who participated: the future of allied health education depends not only on the clinician's institutions recruit, but also on the teachers those institutions help them become. Participants entered academia with years of clinical knowledge, professional judgment, and practical experience. However, clinical expertise did not automatically prepare them for the responsibilities of teaching. They had to learn how to translate what they knew into meaningful learning experiences, recognize how students develop understanding, and accept responsibility

for preparing others to enter the healthcare profession. Their experiences demonstrated that becoming a teacher is not simply a change in position or professional title. It is a process of professional development that involves questioning established assumptions, developing new knowledge, building relationships, reflecting on practice, and gradually embracing a new professional identity. Clinical excellence provides an important foundation for teaching, but the ability to teach requires its own preparation, experience, and continued development.

This distinction carries significant implications for community colleges and allied health programs responsible for preparing the next generation of healthcare professionals. As clinical practice, technology, and workforce expectations continue to evolve, allied health educators must do more than deliver information or demonstrate clinical procedures. They must prepare students to think critically, exercise sound professional judgment, apply knowledge, and provide competent patient care. These responsibilities cannot be separated from the quality of preparation and support faculty receive. Institutions cannot expect clinicians to become effective educators simply because they have demonstrated excellence in clinical practice. When new faculty are left to navigate academic expectations through trial and error, their development depends heavily on individual initiative rather than intentional institutional support. Practical faculty development, meaningful mentorship, opportunities for collaboration, and continued reflection provide a more deliberate approach to preparing clinicians for the demands of teaching. Investing in faculty development is therefore not simply an investment in individual employees. It is an investment in student learning, program effectiveness, and the preparation of the future healthcare workforce.

This study also reinforces that the transition from clinician to teacher does not require individuals to abandon the professional identities they developed through clinical practice.

Instead, participants learned to build upon those identities while developing a broader understanding of their responsibilities. They moved beyond focusing primarily on the care they provided to recognizing their responsibility for the knowledge, skills, confidence, and professional development of others. Some participants arrived at this understanding gradually, while others described moments of uncertainty, reflection, and changing perspectives that influenced how they approached teaching. Their experiences demonstrate that professional identity develops through more than accepting a faculty position. It develops through the decisions educators make, the relationships they establish, the responsibilities they accept, and the ways they respond to the challenges of helping others learn.

Ultimately, the significance of this study rests in recognizing the potential that exists within experienced clinicians, and the responsibility institutions have to help that potential develop. The clinicians who enter our classrooms already know how to care for patients. They bring knowledge and experience that cannot be acquired from a textbook alone. However, knowing how to perform a clinical skill and knowing how to prepare another person to perform that skill safely and competently are different responsibilities. The work of developing educators requires institutions to recognize that distinction and provide the preparation, guidance, and support necessary for clinicians to grow into teachers.

The future of healthcare is shaped not only at the bedside, in the operating room, or in the clinic, but also in the classroom where future practitioners begin to develop the knowledge, judgment, and skills they will carry into patient care. Behind every prepared healthcare professional is an educator who helped make that preparation possible. Many of those educators began their careers as clinicians. Their potential to influence the future of healthcare was never limited to the patients they cared for but extended to the students they would one day teach. If

community colleges expect these educators to prepare the next generation of healthcare professionals, they must recognize that developing teachers is as important as recruiting clinicians. The responsibility does not end when an experienced clinician accepts a faculty position. In many ways, that is where the institution's responsibility truly begins.

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Appendix A - Alignment Table

Problem Based on the Literature	Research Question	Conceptual Framework	Interview Questions	Phase
Limited research on how early-career allied health faculty experience and interpret their professional transition from clinical practice to academia within community college settings.	**RQ1:** How do clinicians describe the evolution of their professional roles during the transition from clinical practice to academic roles?	Questions were structured to identify critical incidents and moments when clinical expertise was insufficient to meet instructional demands, potentially triggering the transformative learning process (Mezirow, 2000).	Q1 Q1, Q2 Q2, Q4	**Phase 1:** Disorienting dilemma. **Phase 2:** Self-examination with feelings of fear, anger, guilt, or shame. **Phase 3:** Critical assessment of assumptions.

Problem Based on the Literature	Research Question	Conceptual Framework	Interview Questions	Phase
Limited research on how early-career allied health faculty experience and interpret their professional transition from clinical practice to academia within community college settings.	**RQ2:** How do these faculty members describe the transformative learning processes encountered during the transition from clinical practice to the academic environment?	Questions were structured to identify critical incidents and moments when clinical expertise was insufficient to meet instructional demands, thereby triggering the transformative learning process (Mezirow, 2000).	Q3, Q6 Q4 Q5 Q5 Q7 Q8 Q8, Q9, Q10	**Phase 4:** Recognition of transformation. **Phase 5:** Exploration of new role. **Phase 6:** Planning a course of action. **Phase 7:** Acquisition of knowledge and skills. **Phase 8:** Provisional trying of new roles. **Phase 9:** Building competence in new roles. **Phase 10:** Reintegration into one's life.

Appendix B - IRB Approval

KANSAS STATE UNIVERSITY | Office of Research Integrity, Compliance and Security

TO: Sandy Robinson
Educational Leadership

Proposal Number IRB-13905

FROM: Lisa Rubin, Chair
Committee on Research Involving Human Subjects

DATE: 07/01/2026

RE: Approval of Proposal Entitled, "From clinician to educator: Transformative learning processes among early-career allied health faculty in community colleges."

The Committee on Research Involving Human Subjects has reviewed your proposal and has granted full approval. This proposal is **approved for three years from the date of this correspondence.**

APPROVAL DATE: 07/01/2026

EXPIRATION DATE: 06/30/2029

In giving its approval, the Committee has determined that:

No more than minimal risk to subjects

This approval applies only to the proposal currently on file as written. Any change or modification affecting human subjects must be approved by the IRB prior to implementation. All approved proposals are subject to continuing review, which may include the examination of records connected with the project. Announced post-approval monitoring may be performed during the course of this approval period by ORICS staff. Injuries, unanticipated problems or adverse events involving risk to subjects or to others must be reported immediately to the Chair of the IRB and / or the Office of Research Integrity, Compliance and Security (ORICS).

Electronically signed by Lisa Rubin on 07/01/2026 12:56 PM ET

203 Fairchild Hall, 1601 Vattier St., Manhattan, KS 66506 | 785-532-3224 | fax: 785-532-3278 | comply@k-state.edu

Appendix C - Interview Protocol

Study Title: From clinician to educator: Transformative learning processes among early-career allied health faculty in community colleges.

Participant Pseudonym: _____

Date & Time: _____

Location (Google Meet): _____

I. Opening Script & Consent

(To be read to the participant at the beginning of the interview)

Good morning/afternoon and thank you for participating in this study. My name is Marc McGaffic, and I am a doctoral candidate at Kansas State University conducting research titled "From clinician to educator: Transformative learning processes among early-career allied health faculty in community colleges."

As we discussed, the purpose of this interview is to understand your experiences transitioning from clinical practice to academia, with particular focus on how you came to see yourself as an educator. I am interested in moments that challenged your prior assumptions, how you reflected on those experiences, and how those reflections influenced your professional transformation into an educator role.

This semi-structured interview will last 60 to 75 minutes. I'll ask open-ended questions about your transition experiences; there's no right or wrong answers; I value your unique perspective.

Your participation is entirely voluntary. You may skip any question or end the interview at any time without penalty. With your permission, I would like to audio-record our conversation for accurate transcription. All identifying information will be removed, replaced with a

pseudonym, and recordings stored securely then deleted post-transcription to protect your confidentiality.

Do you have any questions before we begin? May I start the recording?"

(**Start recorder**)

II. Background Questions

1. To start, tell me about your professional background, including your clinical role and how many years you worked in that role before transitioning to teaching.
2. How long have you been teaching at the community college level?
3. What allied health courses(s) do you currently teach?

III. Guiding Questions

Research Question 1: How do clinicians describe the evolution of their professional roles during the transition from clinical practice to academic roles?

Interview Questions:

1. Tell me about your first experiences during the early weeks or months of transitioning from clinical practice into a faculty role in higher education. For example, what stood out to you about the academic environment, and what were you feeling during that time?

Possible Prompts (if needed):

- Was anything different from what you expected?
- What thoughts were going through your mind at the time?
- What stood out most during those first days or weeks?

2. What aspects of transitioning from clinical practice into a faculty role were the most difficult for you during your first year? For example, were there moments when you felt uncertain or questioned yourself in the role?

Possible Prompts (if needed):

- What challenges did you experience?
- How did you respond to those challenges?
- Did anything surprise you about the role?

3. How did you prepare yourself for the responsibilities of becoming a faculty member? For example, were there areas where you felt unprepared or skills you needed to develop?

Possible Prompts (if needed):

- What skills did you feel you needed to develop?
- How did you learn to teach or manage the classroom?
- What resources or strategies helped you during the transition?

Research Question 2: How do these faculty members describe the transformative learning processes encountered during the transition from clinical practice to the academic environment?

Interview Questions:

4. During your first-year transitioning into academia, how would you have described the differences between being a clinician and being a faculty member? For example, how did your responsibilities or approaches to problem-solving feel different?

Possible Prompts (if needed):

- Did your understanding of teaching change over time?
- Did you approach situations differently in academia compared to clinical practice?
- How would you have compared the two roles at that time?

5. During your first-year transitioning into academia, how would you have described the differences between being a clinician and being a faculty member? For example, how did your responsibilities or approaches to problem-solving feel different?

Possible Prompts (if needed):

- What contributed to your growing confidence or comfort?
- Did a specific event influence how you viewed yourself as a faculty member?
- When did you begin to feel like you belonged in academia?

6. Who or what helped support you during your transition into a faculty role? For example, did colleagues, mentors, supervisors, or conversations with others influence your experience?

Possible Prompts (if needed):

- Were there people who helped you feel supported?
- Did interactions with others help shape your perspective about teaching or academia?
- Did you realize others had similar experiences?

7. Tell me about a time when you adjusted or changed the way you approached teaching or interacting with students as you became more experienced in your faculty role. For example, did you try a new teaching strategy, classroom technique, or way of engaging students?

Possible Prompts (if needed):

- What led you to try something different?
- What did you learn from that experience?
- Did that experience influence your teaching moving forward?

8. In what ways, if any, has becoming a faculty member influenced how you see yourself professionally today? For example, do you describe yourself differently now than when you worked only in clinical practice?

Possible Prompts (if needed):

- Has your understanding of your professional role evolved over time?
- How would you describe yourself professionally today?
- How has being a faculty member influenced your professional or personal values?

9. Looking back on your transition into the academic environment, what experiences had the greatest impact on your growth and development as a faculty member, and why were those experiences meaningful to you?

Possible Prompts (if needed):

- Are there experiences you still reflect on today?
- Did any experiences significantly influence how you approach your faculty role?
- Why do those experiences remain important to you?

10. Looking back, what advice would you give to clinicians who are preparing to transition into a faculty role in higher education for the first time? For example, what challenges should they expect or what would help them feel more prepared?

Possible Prompts (if needed):

- What do you wish you had known earlier?
- What helped you succeed during the transition?
- What would help future faculty feel more supported?

IV. Closing Script

(To be read at the end of the interview)

We have now reached the end of my questions. Is there anything else you would like to share about your experiences that we have not discussed? Do you have any questions for me?

Thank you again for your time and for sharing your valuable insights. Your contribution is incredibly important to this research. As a next step, I will be transcribing our conversation.

Once the transcript is ready, I will send it to you for your review to ensure it accurately reflects our discussion.

Please feel free to contact me if you have any further questions. Thank you once more for your participation.

(Stop recorder)

Appendix D - Letter of Introduction

Subject: Invitation to Participate in Research on Early-Career Allied Health Faculty

Dear [Allied Health Program Director, Dean or Provost]

My name is Marc McGaffic, and I am a doctoral student in the Community College Leadership Program at Kansas State University. I am conducting research for my dissertation, titled: *From clinician to educator: Transformative learning processes among early-career allied health faculty in community colleges*.

I am writing to request permission to recruit faculty members within your allied health programs who have one to five years of teaching experience to participate in interviews for this study. Participation will involve a semi-structured interview lasting approximately 60 to 75 minutes, conducted via a secure virtual platform (Google Meet) at a time convenient for the participant.

I would appreciate your support in sharing this opportunity with eligible faculty. If you or your faculty have any questions about the study or participation, please feel free to contact me at mcgaffic@k-state.edu. This study is being conducted under the supervision of Dr. Sandy Robinson, Principal Investigator. Questions regarding the study may also be directed to: Dr. Sandy Robinson, Professor of Practice, Kansas State University, slrobins@ksu.edu.

Thank you for your time and consideration. Your assistance will contribute significantly to understanding and supporting the transition of early-career allied health faculty in community colleges.

Sincerely,

Marc McGaffic
Doctoral Student, Community College Leadership Program
Kansas State University

Appendix E - Informed Consent

Study Title: From clinician to educator: Transformative learning processes among early-career allied health faculty in community colleges.

Principal Investigator: Dr. Sandy Robinson, Kansas State University, slrobins@ksu.edu

Researcher: Marc McGaffic, Kansas State University, mcgaffic@k-state.edu

IRB Chair: Dr. Lisa Rubin, Kansas State University, rubin@ksu.edu

Purpose:

You are invited to participate in a study titled 'From Clinician to Educator: Transformative Learning Processes Among Early-Career Allied Health Faculty in Community Colleges.' This study seeks to explore how clinicians experience and make sense of their professional transformation as they transition from clinical practice to academic roles, focusing on the transformative learning processes involved.

Who Can Participate:

- Participants must be employed, or have been employed within the past five years, part-time (adjunct) or full-time faculty in an accredited allied health program at a regionally accredited community college.
- Participants are required to hold an active professional license or certification in an allied health discipline, such as anesthesia technology, dental assisting, dental hygiene, surgical technology, physical therapist assistant, or a related field.
- Participants must have a minimum of one academic year (two semesters) of teaching experience at the community college level, teaching in allied health courses.

What You Will Do:

If you choose to participate, you will take part in an individual interview lasting approximately 60 to 75 minutes. The interview will be conducted using Google Meet to ensure an accurate transcription of your responses. The interview will be recorded for playback and transcription purposes. Participants may choose to turn off their cameras at any time during the interview. Interview questions will focus on your experiences transitioning from clinical practice to academic teaching, the development of your identity as an educator, and your evolving professional responsibilities within higher education.

Risks and Benefits:

1. There are minimal risks. You may feel some discomfort reflecting on your experiences. You may skip any question or stop the interview at any time.
2. While there may not be direct benefits to you, your insights can help improve understanding and support for early-career allied health faculty.

Confidentiality:

Every effort will be made to maintain the confidentiality of your responses. Interviews will be recorded using Google Meet and Google cloud service to ensure accurate transcription. Following each interview, the recording will be downloaded and stored on a password-protected external storage device maintained by the researcher. Access to the study data will be limited to the researcher and dissertation committee members, as needed for research oversight and dissertation review.

Pseudonyms will be assigned to participants, and any identifying information will be removed from transcripts, reports, presentations, and publications resulting from this study. All electronic

data will be stored securely and retained in accordance with Kansas State University policies, after which recordings and other identifiable data will be permanently destroyed.

Your information collected as part of the research, even if identifiers are removed, will not be used or distributed for future research studies.

Voluntary Participation:

Participation is completely voluntary. You may choose not to participate or withdraw at any time without penalty.

Contact:

Questions about the study can be directed to Marc McGaffic at mcgaffic@k-state.edu or 947-300-6392. For questions about your rights as a participant, contact MaKenna DeHart makenna@k-state.edu or 785-532-3224.

Consent Statement:

By replying or clicking "I agree," you indicate that you understand the information above and agree to participate voluntarily.

☐

I Agree

Appendix F - Referral/Snowballing Instructions

To support recruitment for this study, participants who meet the eligibility criteria are invited to recommend to your colleagues who may also be interested in participating. The referral process will follow these guidelines:

1. **Eligibility:** Referrals should be early-career faculty (one to five years of teaching experience) employed in an accredited allied health program at a regionally accredited community college.
2. **Voluntary Participation:** Participation in this study is entirely voluntary. Referrals should be made only if the potential participant is willing and interested in learning more about the study.
3. **Confidentiality:** Participants should not share any personal information about colleagues without their consent. The researcher will contact referred individuals directly using only the contact information they voluntarily provide.
4. **How to Refer:** Participants may provide the researcher with the names and email addresses of eligible colleagues, or they may forward the study invitation themselves.

These referral instructions are intended to facilitate snowball sampling while maintaining ethical standards and protecting participant confidentiality.

If you have questions or need additional information, please contact me at mcgaffic@k-state.edu.

Appendix G - Demographic Data

Instructions: Please provide the following information. All responses are confidential and will be used for research purposes only.

1. **Age:** _____ years
2. **Gender:**
    - ☐ Female
    - ☐ Male
    - ☐ Prefer not to say
3. **Years of experience as a clinician:** _____ years
4. **Years of teaching experience in an academic setting:** _____ years
5. **Current faculty rank/position:**
    - ☐ Didactic faculty
    - ☐ Lab faculty
    - ☐ Clinical faculty
    - ☐ Other: _____
6. **Institutional setting:**
    - ☐ Rural Community College
    - ☐ Urban Community College
    - ☐ Suburban Community College
7. **Program discipline / allied health area:** _____
8. **Optional:** Any additional relevant professional experience you would like to share: