ORGANIZING AND IMPROVING CLINICAL EDUCATION PROGRAMS

Elizabeth A. Gavett, M.A.
Boston University

Clinical education coordinators are frequently responsible for monitoring diverse components of academic programs, but the core task for these individuals is to develop and oversee the clinical experiences of the students in their program. Coordinators need to ensure that students meet certification requirements and clinical curricula meet accreditation requirements. These charges are always challenging, but particularly so when new standards are implemented.

This presentation will address some of the challenges of developing and monitoring a cohesive clinical education program. While the major emphasis will be on the clinical curriculum itself, several other areas will be addressed briefly, including monitoring the quality of clinical teaching (in-house clinic and field placement), managing paperwork, and coordinating communication.

As coordinators review and adapt their programs to meet the new standards, it is important to continually strive to ensure that students' clinical experiences reflect what we know about human skill acquisition and learning theory principles.

Clinical programs do not exist in a vacuum; they are part of a larger whole, the university. Each program has its unique context and has to operate within that context. Contextual variables do affect how a clinical program is constructed. Variables include

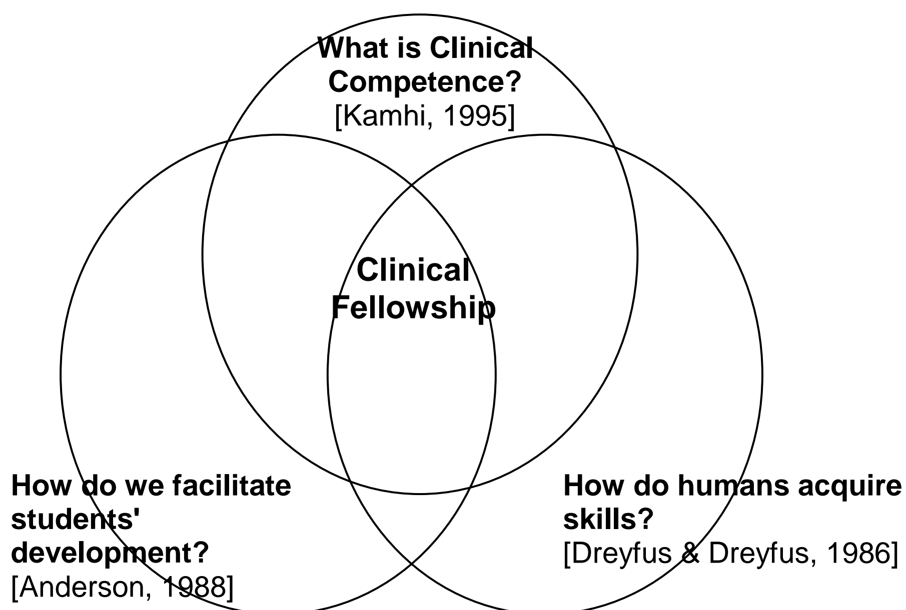
- Personnel: Who supervises students? (faculty who teach the

classes, clinical faculty, professional staff, etc.)

- Resources: What clients/populations/settings are available?
- Institutional fiscal constraints: Is the clinic a self-sustaining unit or subsumed under the departmental budget?
- Regardless of the different contextual variables that influence a program's structure, the goal of a clinical education program is universal: to prepare graduates to be competent speech-language pathologists. How do we do just that?

There are several core questions that should guide and influence our planning and decision-making. What is clinical expertise? How do humans acquire complex skills? How do supervisors facilitate development of these skills? There are various models that describe clinical expertise, skill acquisition, and supervision that can be used for the development of clinical programs. The three models that have influenced the development of the Boston University clinical program are Kahmi's conceptualization of clinical expertise (1995), Dreyfus and Dreyfus' human skill acquisition model (1986), and Anderson's supervision model (1988) [Figure 1]

Figure 1



Several guiding principles relevant for organizing and developing clinical education programs emerge from these models.

- Students move from "knowing that" to "knowing how" (Dreyfus & Dreyfus, 1986) as they move through distinct stages of skill acquisition. During each stage, they have different perceptions about the role of the speech-language pathologist and they engage in different modes of decision-making as they develop competence.
- Self-monitoring skills are critical (Kahmi, 1995).
- Supervisors need to modify their input to supervisees over time (Anderson, 1988).

Boston University Clinical Curriculum [See Tables 1 & 2.]

Although the central task of monitoring a clinical curriculum focuses on the clinical experiences of the students, it is certainly not the only task that faces the clinical education coordinator. Other challenges include: monitoring the quality of clinical supervision, managing paperwork, and coordinating communication.

- Monitoring quality of clinical teaching
  [Discussion of academic/clinical faculty interactions; mentoring/preparing new alumni to serve as clinical supervisors; supervision workshops for field placement supervisors]
- Managing paperwork and coordinating communication
  [Discussion of multiple uses of *Blackboard* (formerly *CourseInfo*)]

Table 2

Boston University
Overview of Clinical Experiences
Master of Science in Speech-Language Pathology

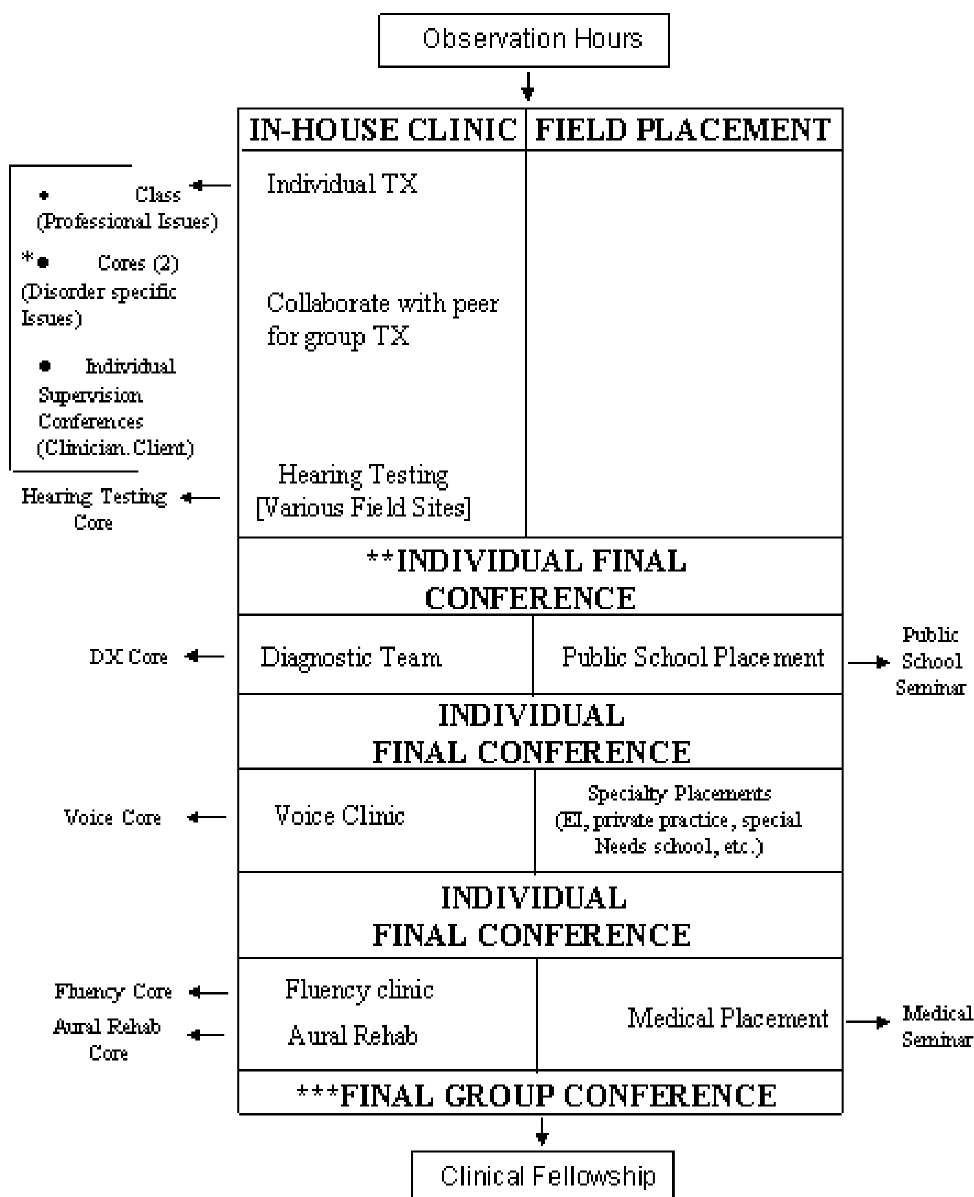


Table 2: Definition of Terms

* **Core:**

[American Heritage Dictionary definition of *core*: "the most important part of anything"]

A *Core* is a clinical discussion group focused on a particular disorder area led by the clinical supervisor who supervises in that area. *Cores* provide an efficient mechanism for clinical supervisors to assist students in bridging the gap between theory and practice. Topics covered in *Cores* vary depending on disorder area and level of the students, but generally cover issues related to goal setting, intervention strategies, documentation issues, materials, etc. *Cores* also provide a forum for facilitating peer problem-solving skills and case study discussions.
All students seeing clients in the Boston University Clinic attend *Cores*. If a student is seeing a client with fluency concerns, s/he attends the Fluency Core; if a student is seeing a client with language concerns, s/he attends the Child Language Core, etc. *Cores* meet on a weekly (1 hour) or bi-weekly (hour and a half) basis.
During the student's first semester of clinical practicum, students attend *Cores* in addition to individual weekly supervision conferences. During subsequent semesters, individual supervision conferences are scheduled as needed.

** Individual Final Conferences:

Individual Final Conferences are ten-minute oral presentations made to the entire clinical faculty at the end of each semester a student is enrolled in practicum. Students are required to provide a critical summary of their clinical growth and development over that semester and to set appropriate personal goals for the next practicum experience.

*** Final Group Conference:

A *Final Group Conference* is a group meeting held at the end of the semester for all graduating students and the clinical faculty. Students are required to reflect critically on the clinical curriculum and provide feedback about program components that facilitated growth and make suggestions for strengthening the program.

References

Anderson, J. (1988). *The supervisory process in speech-language pathology and audiology*. Boston: College Hill Press.

Kamhi, A. (1995). Defining, developing, and teaching clinical expertise. *The Supervisors' Forum*, 2, 30-35.

Dreyfus, H., & Dreyfus, S. (1986). *Mind over machine*. New York: The Free Press.

Summary of Participants' Discussion

• Individual program differences

Considerable discussion and interaction focused on the variety of ways programs structure clinical training (e.g., how many clients students are assigned, when students begin field work, when clinic meetings are scheduled, content and nature of clinic meetings, opportunities to observe master clinicians, etc.)

• Maintaining good relationships with field placements

Programs vary significantly in the number of hours students must accrue in the in-house clinic before being assigned to a field placement (about 30 to about 150). This led to discussion about how to increase a sense of partnership with field placement supervisors who might be more willing to take students with limited clock hours. The importance of developing good relationships and visiting sites when problems arise was discussed. Participants shared ways they involved field placement supervisors in their programs (e.g. guest lectures in

classes, clinic meetings, and rounds; appreciation workshops with free continuing education opportunities; involvement on appropriate committees, etc.)

• Individual final conferences

Boston University's individual final conferences (see Table 2: Definition of Terms) were discussed as an effective mechanism for formative assessment under the new certification requirements. Other programs using this format shared how they conducted conferences and gave feedback to their students.