

FACING THE FUTURE: THE CHANGING LANDSCAPE FOR CLINICAL EDUCATION DIRECTORS

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BELIEF: One is best prepared for the future by reflecting on the past and assessing the present.

RESPONSIBILITIES: Three major responsibilities of the clinical education director:

1. Managing the standards
2. Preparing the student body for clinical practice (technical skills)
3. Preparing graduates to enter the workforce (professional skills)

ISSUES TO EXAMINE:

I. Standards

Challenge: *How is your program increasing the variety of clinical opportunities that both meet the new standards but also keep supervision costs down?*

II. Student body

Challenge: *How does your program systematically move students from “knowing that” to “knowing how” (Dreyfus & Dreyfus, 1986) while effectively addressing students’ different learning styles?*

III. Workplace skills

Challenge: *How does your program prepare graduates to acquire successful workplace skills and core professional values?*

PROCESS: Audit completion

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The Ever-Changing Landscape for Clinical Education Directors

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When Susan and I were approached by the committee to participate in the pre-conference activities, we were pleased to be able to merge our 60 plus years of collective experiences as clinic directors and clinical educators along with our experiences on various local, state, and national committees in order to share with you our perceptions of the future landscape for SLP clinical education directors. We have lived through various trends in clinical education and been fortunate not only to be part of them but also to have influenced some of them.

Historians tell us that in order to plan for the future, we must examine the past. Our premise for today's presentation is a modification of that belief. We believe that one is best prepared for the future by reflecting on the past and thoroughly assessing the present. Toward that end, we will share with you our experiences and beliefs as clinic directors about the major challenges we encounter and some of the ways we have attempted to creatively address challenges in our own programs. We will also challenge you to examine your own programs. We want to make it clear that this is not a research presentation. This is a presentation for and by clinical educators rooted in our joint experiences, beliefs and perspectives.

Here is our plan for the afternoon. After a brief introduction to the topic of our presentation, we will jointly discuss those themes that underscore our interpretation of the challenges that clinic education directors face. In the last fifteen minutes we will review what we are calling an *audit* of a program's level of preparedness. This is a very informal tool to help you to identify where your program's needs lie and to give you some ideas of how you are positioned to deal with the challenges that they pose.

Here are the outcomes of the presentation that we have planned for you:

Participants will:

- 1) Describe the clinical education director's responsibilities in effectively managing the demands of: the student body, clinical externship experiences, and certification standards;
- 2) Describe the changing characteristics and needs of SLP graduate students and their implications for clinical preparation, and
- 3) Complete an analysis of their clinical education program's resources, deficiencies, and needs for facing the future.

We need to acknowledge that our profession does not exist in a vacuum. We are influenced by what is happening around us. Recent changes in health care have required

practitioners to be more accountable - to demonstrate results and to demonstrate those results in less time. Recent changes in educational accreditation practices have shifted from being process oriented to outcome oriented. And ongoing sociological and demographic changes have required educators to be better versed in teaching to different learning styles.

Clinical education directors are expected to establish and manage clinical programs that, by nature, are dynamic. In recent years, we have been presented with different challenges that have required us to be reflective and resourceful, fully testing our ability to manage change. These changes in the larger world of health care, educational accreditation and demographics I've just cited have presented challenges for us as clinic directors. In the late 90's, the Medicare cap made securing adult medical placements more difficult than ever. The 2005 ASHA Standards required a significant paradigm shift from planning opportunities to obtain hours to planning opportunities to demonstrate skills. And the increasing diversity of the student body from 22 years old CSD majors to students of different ages, from different backgrounds, and different countries reminded us that "one size fits all" clinical education is neither appropriate nor effective.

As clinic directors, we operate in different contexts [urban versus rural settings, public versus private universities, self-supporting clinics versus departmentally- funded clinics] but we all seek to prepare students with different backgrounds to demonstrate the same standards and have them enter the workforce to compete for the same jobs.

The purpose of today's presentation is to examine some of the issues and challenges associated with three variables a clinic director must manage: the standards, the student body, and externships/workplace. By realistically examining your program's context, resources, strengths, vulnerabilities, and challenges, we hope you will prepare yourself to face a landscape comprised more of rolling hills and meadows than seemingly insurmountable hills and landmines.

Issue I: THE STANDARDS

Challenge: *How is your program increasing the variety of clinical opportunities that both meet the new standards but also keep supervision costs down?*

If we look at the history of the clinical certification process, not much had changed over a four decade period from the 1963 Minnesota conference until the 2005 standards. During those 40 years, students were expected to take X number of credits of coursework in different areas and complete X number of clock hours in different categories. Yes, the number of hours in particular categories changed over the years and the conceptualization of hours from discrete disorders, i.e., articulation, voice, to broader categories, i.e., "speech" and "language" changed, but these changes only required us to add or subtract from what we were already doing. We were operating within the same known and comfortable paradigm, just with different numbers. The 2005 Standards, however, represented a significant paradigm shift for all of us. It required us to:

- THINK differently about how we're preparing students ("skills" not "hours"), and to
- GOVERN ourselves (programs decide hour minimums, skill adequacy) rather than follow explicit ASHA-designated requirements. We now have to decide what constitutes "adequate" or "satisfactory" skill demonstration and decide if we want/need to set hour minimums.

The new standards do not require students to demonstrate skills with live clients. Students can demonstrate skills in simulated situations. But if we believe the gold standard in clinical training is face-to-face contact with clients, then how do we work toward increasing the variety of clinical opportunities for our students, given the new standards "Big 9?" We wonder if any of these questions resonate with you.

How do I provide experience with diversity in a relatively heterogeneous rural setting?

How can more students be exposed to clients with low incidence disorders?

How can I cover the costs for supervision if I increase clients/populations seen in the clinic?

Although our programs exist in different contexts and face different specific challenges, many of the barriers preventing clinic directors from developing a greater variety of clinical experiences involve these two factors:

1. *Access* to specific populations
2. *Costs* associated with supervision

We thought it would be helpful to present how our programs are addressing these challenges. During past years, most clinical training was conducted in traditional university settings and traditional externship settings. The changing landscape in clinical training is almost forcing us to think outside the box and look for new and creative ways to access populations and still afford quality supervision. Here are some examples of challenges and creative problem-solving that have resulted in cost-effective and meaningful clinical training experiences for students in our programs.

Challenges:

How do we provide sufficient experiences with adult language clients in a city where there are three other graduate programs?

How can we provide a quality experience with voice clients during a single semester? (Problem: Voice client attendance was very inconsistent.)

How can we better prepare our students to provide services in an educational setting?

How can we increase the number of students exposed to clients with lower incidence disorders (feeding/fluency)?

How can we provide meaningful experiences for students in prevention activities?

In a rural setting how does the university clinic provide sufficient experiences for its students in order to achieve competency in the nine areas specified in the 2005 Standards?

In a rural setting, how do we provide students with sufficient breadth in their experiences to meet requirements for: multiculturalism, range of ages, severity of disorder, and range of disorder?

In our location – that is, rural and far from our university hospital – how do we provide experience teaming with other disciplines?

[Description of how programs have addressed each of these challenges.]

As you can see, these clinical training opportunities do not fit the “traditional clinical model” as we have known it in the past, i.e., client calls university clinic to set up an appointment. As we face the future, it is clear that collaboration is part of the changing landscape. Contracts, community groups, colleagues, and clinical researchers become the “4 C’s” clinical education directors need to look toward to form vital partnerships in clinical training.

Issue 2: STUDENT BODY

Challenge: *How does your program systematically move students from “knowing that...” to “knowing how...” (Dreyfus & Dreyfus, 1986) while effectively addressing students’ different learning styles?*

The essence of the job of clinical education director is to ensure that students become clinicians. Toward that end, we are required to develop and manage the sequence of experiences that comprise a student’s program. In order to do that effectively, we need to understand how humans develop complex skills, or how individuals move from classroom learning, “knowing that.” to successful clinical performance, or “knowing how.” One model that is very helpful in understanding this process is the Dreyfus & Dreyfus model of skill acquisition (Dreyfus & Dreyfus, 1986).

[Description of model and five stages: Novice, Advanced Beginner, Competent, Proficient, Expert]

As you can see, the progression is not a linear progression but a non-linear progression. We need to make sure that the sequences of experiences we develop for our students take into consideration the way humans develop complex skills.

As programs seek to recruit students from under represented groups, international students, and non-traditional students we need to shift from a “one size fits all” clinical supervision perspective toward one that acknowledges different learning styles. One model that describes adult students’ learning styles is taken from the Health Sciences Faculty website. It is built on four dimensions that are somewhat divergent – sensing, feeling, intuitive, and thinking - and it includes the performance tasks that compliment them. While we do not believe that we could neatly categorize all of the students with whom we have worked into one of these four style descriptions, the performance strategies do provide us with good ideas for altering instructional strategies to better address students’ learning differences. To illustrate this, let me share with you an

example of how one can modify a particular clinical task where the outcomes for the students will be the same, but the process for achieving them will be different depending on their learning styles. The challenge here for us as clinical educators is to enable students to reach the same level of knowledge and skills while also providing them with alternative avenues for achieving that level.

[Description of clinical problem and application of Model.]

www.healthsciencefaculty.org
(2004)

		Sensing			
		Mastery Learner <i>(Sensing Thinker)</i>		Involvement Learner <i>(Sensing Feeler)</i>	
Thinking		List Identify Sequence Match Describe Who/What/When/Where/Why?		Opinion Belief Discuss Share Like/Dislike What does it mean to me?	Feeling
		Understanding Learner <i>(Intuitive Thinker)</i>		Synthesis Learner <i>(Intuitive Feeler)</i>	
		Compare/contrast Debate Support/refute Demonstrate Why? How?		Create Illustrate Build Metaphor/simile Design Suppose Imagine What if...?	
		Intuitive			

One of our tasks as clinic director is to “supervise the supervisors.” A challenge for the future is to encourage and instruct our supervisors to better meet the needs of all students, not just the students who learn in the historically accepted manner – read, absorb, and put into practice. Many supervisors naturally adapt their teaching styles to the learning styles of their students, doing many of the things described above. But if supervisors were better informed about learning styles, they could become more efficient in the way they presented information to supervisees and supervisees would probably meet with greater success.

Issue 3: THE WORKPLACE

Challenge: *How does your program prepare graduates to acquire successful workplace skills and core professional values?*

The process of “transitioning” students to off-campus sites is often a big step for both students and clinical educators alike. Off-campus supervisors frequently expect that students will arrive ready to “hit the ground running” and assume they have the

knowledge and skills necessary to function comfortably in that particular setting. These expectations may be quite consistent with what the student has acquired to date. They may be an underestimate of the student's readiness, or as sometimes is the case, they may exceed the student's readiness to assume the responsibilities of the assignment. Years ago, as clinical education coordinators, we depended on off-campus sites to supplement what we at the university were unable to provide. Off-campus experiences were intended to fill in the gaps, to provide a variety of clock hours not available in the university clinic and to enable students to develop specialty skills that complimented their academic experiences. Now, off-campus supervisors frequently expect that students will come to their sites fully ready to take on the rigors of service delivery. The students are far more "CF ready" (a term coined by Marilyn Wark at Memphis State University) while still in their programs than many of us ever were.

In transitioning students from the University clinic to the externship setting, the challenge is not just how to get students ready to apply (and gain more) knowledge and skills. It is also about facilitating their development into the role of "professional" and shaping or sharpening those intangible skills that we recognize as necessary for success in the workplace.

Quite often, the challenge for the clinical educator is how to most effectively capitalize on those events, experiences, and activities where workplace skills are embedded. It is easy to structure situations that result in demonstrations of knowledge and skills with specific outcomes (i.e., accurate data collection or identifying the difference between language delay and language disorder), which we acknowledge or reward with verbal and/or written feedback. However, cultivating "workplace skills" takes much more effort because we need to recognize where the opportunities reside and then we need to exploit those teachable moments. In this sense, honing workplace skills is not really an objective in itself, but rather the by-product of real or simulated situations, opportunities, and experiences that usually focus on demonstrating knowledge and skills. Our task as clinical educators, then, is to recognize and point out evidence of successful workplace skills.

In his book, *Working with Emotional Intelligence* (1998), Daniel Goleman summarizes what employers value in their employees. We've extended this to what off-campus sites want, because in our conversations with externship supervisors, we've learned that these are characteristics that they, too, seek in students assigned to their settings. While supervisors value technical skills, the "how to do" aspect of the students' preparation, they also value the "how to be" skills of flexibility, critical thinking, investment, and responsibility.

ASHA's briefing paper (1998) described nine important workplace skills [Planning and priority setting; Organizing and time management; Managing diversity; Team building; Interpersonal savvy and peer relationships; Organizational agility; Conflict management; Problem solving, perspective, and creativity; Dealing with paradox and learning on the fly] that employers in our profession value, reiterating many of those that Goleman

summarized. They, too, express the need for flexibility, problem-solving, and strong interpersonal skills in employees. As clinical educators, we need to make sure then, that in addition to having the technical skills required by externship sites, that students also have the professional skills required to be successful in the workplace.

Self-study

Review of the Self Study tool (attached).

Bibliography

ASHA (1998). *Responding to the Changing Needs of Speech-Language Pathology and Audiology Students in the 21st Century: A Briefing Paper for Academicians, Practitioners, Employers, and Students.* www.asha.org. (2005).

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

Goleman, D. (1998). *Working with Emotional Intelligence.* New York: Bantam Books.

www.healthsciencefaculty.org (2004).