

FACILITATING EXCELLENCE IN ACADEMIC AND CLINICAL TEACHING

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The reality concerning teaching excellence is that “more often than not, academics are employed for their research capabilities, based on their publications in accredited journals, rather than for the quality of their teaching” (McLean, 2001). We often talk about the current generation of students in our programs, noting that “Generation X” is at odds with other generations. Hays (1997) notes that this is a generation with unique abilities to absorb information through technology. Student characteristics include:

- Technologically literate
- Highly independent problem solvers and self starters
- Responsive and focused
- Ambitious and fearless
- Crave stimulation
- Prefer concrete and specific information
- Desire personal interaction and constant feedback
- Desire to learn leading edge technology
- Seek a balanced lifestyle
- Parallel thinkers able to perform multiple tasks simultaneously

Collins (2000) surveyed 52 Allied Health ‘Generation X’ students and the results suggested that teachers should consider doing the following:

- Be nurturing (73%)
- Be challenging (96%)

- Accommodate individual student abilities and learning (81%)
- Provide group activities that promote critical thinking (78%)
- Learning is more important than obtaining good grades (76%)

The above characteristics and survey answers seem to suggest that technology should be incorporated into clinical teaching. They also suggest that we should expect questions about the purpose, the relevance, and the ultimate outcome of what our students are learning, or at a higher level than “is this on the test?”

We have noted the above student characteristics in our academic classrooms as well. There has been a shift from ‘teaching’ to ‘learning’ and the “scholarship of teaching” has become one of four scholarships as presented by Boyer (1990).

With all that we are told and read about this new generation of students in our classrooms, what can we learn from them to structure our learning experiences for them? Students at Wichita State University were asked to write one or two learning objectives for the instructor of an introductory class. The most frequently mentioned objectives were that the teacher:

- Provide an outline or PowerPoint for the chapter
- Provide visual aids (movies, media clips)
- Provide examples to supplement readings
- Provide a foundation that students can build on in the future
- Provide a perspective on current issues, how they will impact persons with speech, language, and hearing problems
- Facilitate knowledge of disorders with real people and their experiences
- Make class interesting
- Be flexible
- Be able to work with students.

When questioned about the objectives for the content of an introductory class, they responded with the following suggestions:

- Students should learn the types of communication disorders
- Students should learn how communication disorders affect those who have them
- Students should learn how to study for a test and do good (sic) on the test
- Students should be respectful to the teacher
- Students should learn to look at the person first, then the problem
- Students should learn to address people with disorders as equals

Students in an upper division CSD course, listed the following desirable instructor objectives:

- “An instructor with qualifications should present the material in a highly effective format including PowerPoint, clinical experiences, and valuable sources that students can use in the future as a working professional in CSD.”
- Make the tests cumulative
- Review concepts and build on them
- Provide an optional information list
- Provide both independent and collaborative learning opportunities based on the most current material
- Provide current videos, case studies, latest research, observations in the clinic.

In a slightly different twist, students at Nova Southeastern University were asked to report what objectives they expected to accomplish in their clinical/externship experiences.

Their responses were as follows:

1. Write a quick and comprehensive SOAP note after each session.
2. Learn clinical writing skills needed in order to write progress reports.
3. Evidence behavior management skills for different clients with different disorders.

4. Interact and communicate with parents, teachers, and others regarding the client's goals and be able to integrate others' concerns into speech/language goals to facilitate generalization of skills.
5. Manage a diverse case load and "juggle" multiple tasks within a set time frame (i.e. back to back clients and behavior management with a variety of presentations).
6. Have a better understanding of the clinical process (building rapport, establishing goals, implementing goals, adjusting goals as needed, and documenting change).
7. Accurately describe client's condition and provide rationale for goals (relevancy, researched based techniques).
8. Present with improved recognition and management of potentially difficult interactions between team professionals, clients, and families.
9. Begin to see the light at the end of the tunnel and begin to smile more consistently with minimal prompting and cueing from their friends and family. 😊

Strategies for Excellence in Clinical Teaching

Strategies for excellence in clinical teaching can also be adapted to the academic setting. The following discussion will include relationship awareness, communication, and the use of concept maps and reflective journals. Finally, peer evaluation and a discussion of accommodations for students with special needs will be presented.

Relationships and clinical teaching require positive supervisory characteristics include flexibility, concern, attention, investment, and openness. We should consider the value of empathy, and devote time to analyzing our personal interactions with students, and work to improve them, if needed. We know that not one relationship style suits all supervisees. We need to be aware that the supervisor carries an amount of power, and that, in most cases, intimidation is not a factor that will facilitate supervisee growth. Finally, friendship is probably not a relationship that suits the outcomes needed. McCrea and Brasseur (2003) stated it well: "the

very essence of this component (interpersonal communication) is mutual understanding, not only of the mechanics of the process, but also of the other person in the interaction.”

Supervisees may benefit by restating supervisory recommendations. This can provide evidence (or lack thereof) of the clarity of their understanding through the provision of feedback. It may be helpful to watch a session recording together or to listen to a taped sample together. We need to develop and use listening skills that reflect interest (Pickering & McCready, 1990)

Concept maps are metacognitive tools to assist learners in the development of self-appraisal of their own thinking processes. Maps can foster consideration of evidence drawn from clinical practice, and are helpful as we want to move learners from memorizing to organizing and relating concepts into their cognitive structures. We know that meaningful learning includes concepts of new material, concepts of what the learners already know, and concepts from the context in which the learners are engaging in the learning. Concept maps reveal patterns and relationships and help students to clarify their thinking, to process, organize and prioritize. Through positioning ideas and moving them around on the screen, students learn to see how the ideas are connected and understand how to group or organize information effectively.

Reflective journals can be useful if clinical educators/supervisors provide clear expectations for journal entry. They offer a way to learn from unsuccessful attempts or to recognize a successful strategy, and create a “culture of inquiry” (Lieberman, 1995). Lyons (1999) stated that journal writing promotes development of reflective skills among healthcare students, and that development of reflective skills made students more confident in their learning, fostered responsibility and accountability, and assisted in integration of theory and practice.

Loo and Thorpe (2002) suggested that students consider the following questions as they begin to write:

1. What was the learning situation/event?

2. What have I learned and how did I learn it?
3. How do I feel (good and bad feelings) about what I learned?
4. How could I have learned more effectively/efficiently?
5. What action(s) can I take to learn more effectively/efficiently in the future?
6. In what ways do I need to change my attitudes, expectations, values and the like to feel better about learning situations?

The following suggestions were provided to students:

- Pick a quiet place and reflective time to do journal entries.
- Entries should be done at least twice weekly.
- The stated questions stimulate ideas and maintain focus on learning - feel free to discuss other questions/topics or incidents judged to be important.
- Be self-aware, honest, and open in reflection. Go from genuine self-awareness to self-evaluation to actions for improvement.
- The process might be described as guided journaling. Journals can be submitted in electronic form and students receive individual feedback on their journal.
- Need to pair journaling with specific journaling objectives.
- Journals are confidential.
- The instructor should keep a journal before having students do so.

Peer evaluations can be used in both clinic and academic settings. There are several questions and cautions, however, before beginning evaluation by peers (Drexler, et al. 2001; Greguras, et al. 2001). They include:

- How useful are they?
- One's own performance may influence the willingness to evaluate peers.
- It is important to provide training in peer evaluation prior to initiating the process.
- Be certain that students are comfortable with the idea of peer evaluation.

- It is likely that peers observe a more realistic sample of behavior – supervisees may alter their behavior around supervisors.
- Peers (if friends) may be unwilling to provide accurate ratings.
- Some students may rate everyone the same way to avoid friction within the group.

The area of accommodations in the clinic is a hard one. Most clinics will have procedures in place, but will have to individualize depending upon the type of accommodations necessary. Some ideas might include providing a student with time and a half as the result of a diagnosed disability. We may have to provide additional time between clients or follow requirements of the office of disabilities at the university. There are technological support systems to assist in the cases of visual impairments/hearing impairments. The University clinic is not the issue in most cases as we have more control of changes that can be made. It is more difficult in off-campus sites.

In off-campus sites, we often work with the student to find the right/best placement. A major dilemma we face is if we “warn” the off-campus supervisor or not. Perhaps we can highlight the student’s strengths, suggest a pre-practicum interview and prepare the student to showcase his/her work through portfolio review, de-identified tapes of therapy sessions, etc. Course and clinic syllabi should be detailed as to the expectations of the department and the institution, and the standards (licensure and certification) to be met. Students should be familiar with the KASA standards, how they are tracked, and expectations for knowledge and skills.

Strategies for Excellence in Academic Teaching

As mentioned above, many of the strategies for clinical teaching can be applied to the academic setting as well. Many faculties are turning to regular agenda items about teaching to promote conversations about successful teaching strategies, class management, test construction, etc. We have found that informal discussions can be helpful as well. A Friday afternoon group often works well!

Additional information and ideas can usually be found at your institution's teaching center. Look there for presentations, programs, and resources. For example, programs presented this year through the Center for Excellence in Teaching and Research at Wichita State University included "Podcasting in the Classroom" and "Wikis, Blogs, Discussion Groups, Blackboard, and PowerPoint, Oh-My!" Examples from other teaching centers include "Teaching Nuggets" from the USC Center for Excellence in Teaching, "Preparing for Peer Observation" from the UT-Austin Center for Teaching Excellence, and a session on "Clickers in Class" from the Searle Center for Teaching Excellence at Northwestern University. The websites for the above mentioned centers are as follows: www.usc.edu/programs/cet/resources, www.utexas.edu/academic/cte, and <http://teach.northwestern.edu>.

University teaching centers also will often highlight faculty members who have won teaching awards and are available for consultation. We have found that these faculty members welcome classroom observations and conversations about teaching excellence. Such visits and conversations may be used to promote further department discussions.

Finally, asking our students about their learning preferences can often yield interesting answers! A more formal approach can be found in "Classroom Assessment Techniques" (Angelo & Cross, 1993).

In summary, we have found many pathways to facilitating excellence in our academic and clinical teaching. We hope this presentation has stimulated ideas and provided encouragement for your own journeys.

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