

QUALIFICATIONS OF CLINICAL EDUCATORS

Lisa Lucks Mendel

University of Memphis

Judith Brasseur

California State University, Chico

Elizabeth McCrea

Indiana University

Introduction

The academic and clinical education of audiologists and speech-language pathologists is critically important to our professional community. Our expanding scopes of practice, the increased need for speech, language, and hearing health care services, and the latest changes in the requirements for professional practice, make it paramount that we continue to address important issues related to the clinical education of our students. This panel addressed the knowledge and skills that clinical educators working in both university and offsite settings should be able to demonstrate. Clinical educators in both settings have dual roles, one as clinical educator and one as service provider. The need to be accountable for patient needs, while fostering the professional growth of student clinicians, may cause some challenges. This presentation addressed issues related to these dual responsibilities and outlined important characteristics for quality clinical educators.

Supervision

The supervisory process guides and supports the learner through hands-on clinical training with the goal of developing clinical and professional knowledge and skills (Newman, 2005). The emphasis is typically on the **process** of supervision, which Anderson (1988) defined as

“a process that consists of a variety of patterns of behavior, the appropriateness of which depends on the needs, competencies, expectations, and philosophies of the supervisor and supervisee and the specifics of the situation (task, client setting and other variables).

The goals of the supervisory process are the professional growth and development of the supervisee and the supervisor, which is assumed will result ultimately in optimal service to clients” (p. 12).

When discussing the process of supervision and the qualifications of clinical educators, it is also important to consider the variety of terms that are used to describe these individuals. Some of these terms include: supervisor, preceptor, clinical educator, coordinator, consultant, head clinician, and clinical teacher. These terms connote differences in roles, as well as labels that are preferred in different sites where clinical education occurs.

Challenges of Supervision

The greatest challenge that clinical educators face is to make available appropriate clinical care to the client within the context of providing meaningful learning experiences for the student clinician. Finding this delicate balance between meeting the educational needs of the student clinician without sacrificing quality clinical services to the client is often very difficult to accomplish. One way to achieve this is for the clinical educator to establish and maintain an effective working relationship with the student clinician. To be effective, the clinical educator needs to be aware of the student’s academic background, strengths, weaknesses, professional needs and expectations. The 10 competencies associated with the task of establishing and maintaining an effective working relationship contained in ASHA’s (1985) Position Statement on Clinical Supervision, include the ability to:

1. Facilitate an understanding of the clinical and supervisory processes
2. Organize and provide information regarding the logical sequences of supervisory interaction
3. Interact from a contemporary perspective
4. Apply learning principles to the supervisory process
5. Apply skills of interpersonal communication in the supervisory process
6. Facilitate independent thinking and problem solving by the supervisee
7. Maintain a professional and supportive relationship

8. Interact with the supervisee objectively
9. Establish joint communication regarding expectations and responsibilities
10. Evaluate, with the supervisee, the effectiveness of the ongoing supervisory relationship

In addition, clinical educators need to be friendly, respectful, supportive, concrete, genuine, and empathetic (Audiology Summit, 2006; McCrea, 1980).

Triangulation of Communication

The interaction between the clinical educator and the student clinician is a fundamental aspect of the clinical practicum experience. A clear understanding of the roles and expectations of both parties will help to avoid misunderstandings and unmet needs (Kelly, Davis, & Hegde, 1994). Clinical educators have expressed that they expect that students will demonstrate initiative; accept constructive feedback; be open to learning new methods; be able to self-evaluate, problem solve, and troubleshoot; be responsible for their own learning; make and learn from their mistakes; be appreciative of the clinical educator's time and expertise; communicate needs; be collegial; and be an ambassador for their university program. In addition, there should be clear, frequent, and documented communication between the university and the clinical educator, between the student and clinical educator, and between the university and the student.

Ensuring Quality in our Provision of Services

Quality characteristics for clinical sites cannot be separated from quality characteristics of clinical educators. Thus, before addressing the characteristics of quality clinical educators, the services provided by these individuals must be considered. Clinical educators have a multifaceted job that is setting and situation dependent, and it is evident that service delivery can be affected by workplace demands.

Quality clinical experiences should promote a progression of student skills and didactic instruction that leads to independence. These opportunities should be adequately diverse to cover the full breadth and depth of the scope of practice and allow sufficient practice and

repetition to ensure skill mastery. Supervision should reflect this progression and be commensurate with the clinical skills of the student. In fact, the current CFCC standards for speech-language pathology (ASHA, 2005) and audiology (ASHA, 2007) state that the amount of supervision a student receives must be appropriate to the student's level of knowledge, experience, and competence. All clinical practices should be evidence-based, and the evidence should be clearly articulated by one or both parties. Initially the clinical educator may model this behavior but as student clinicians assume more responsibilities and are able to function with higher levels of independence, they would be expected to clearly describe the rationales and evidence to support selected practices.

Characteristics of Quality Clinical Educators

Clinical educators often assume a broad array of distinct roles including being a professional, researcher, academic/clinical educator, administrator, clinician/master clinician, facilitator, counselor, mentor, and coach. They must examine how their personal preferences and philosophical views influence individual role choices and the execution of selected roles. They must also be able to demonstrate the effectiveness and efficiency of both clinical and supervisory practices. This does not imply, however, that clinical educators will be experts in every aspect of practice. But, they model ethical behavior by consulting with other professionals and by acquiring knowledge and skills when presented with new challenges.

Our Proposal. Based on the literature described in a variety of sources but first articulated by the 1982 ASHA Committee on Supervision, we propose the following minimal qualifications for clinical educators: degree/credentials, professional experience and coursework in supervision. First, clinical educators should hold appropriate credentials that will enable the student to subsequently apply for national certification, state licensure and/or a teaching credential. Second, clinical educators should have a *minimum* of three years of clinical experience (more than 5 years is desirable) – especially in their areas of special expertise. They should have a *minimum* of three years of experience in their current site/work setting as well.

Not only experience, but also special preparation for the role of clinical educator is essential. It is critical that clinical educators view supervision as a distinct area of practice and expertise. Knowledge and skills in supervision imply that clinical educators should be able to demonstrate the 13 tasks for effective supervision (ASHA, 1985) at a level appropriate to their work setting and the needs of their supervisee. Effective clinical supervision begins, but does not end, with the demonstration of “quality clinical skills” (ASHA, 1985).

Finally, quality clinical educators should also have appropriate personal characteristics that make them effective supervisors. Quality clinical educators should be *reflective* and should be able to effectively analyze their behaviors and interactions and tailor their practices to best meet the needs of a particular student (Casey, 1985; Casey, Smith, & Ulrich, 1988; Culatta & Seltzer, 1976; McCrea, 1980; Smith, 1980; Smith & Anderson, 1982; Underwood, 1979). They should have a desire to mentor and help prepare new generations of speech-language pathologists and audiologists.

Recent Evidence. An Audiology Education Summit was held in January, 2005 that identified and described indicators of quality that could be used to assist programs in developing, evaluating, and enhancing clinical doctoral education in audiology. A second Audiology Education Summit was held in February, 2006 that focused on models and issues of clinical education. The two Summits assembled academic and clinical educators from clinical doctoral programs in audiology and representatives from clinical facilities and related professional organizations to identify and describe indicators of quality that would enhance clinical doctoral education. These education summits were co-sponsored by the Council of Academic Programs in Communication Sciences and Disorders (CAPCSD), the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA), the American Academy of Audiology (AAA), and the American Speech-Language-Hearing Association (ASHA).

One of the topic areas covered during both education summits dealt with the

characteristics of quality clinical educators. Despite the fact that these summits included primarily audiologists, the characteristics determined to be important can certainly be applied to speech-language pathology as well. The following quality characteristics of clinical educators were discussed during the Audiology Education Summits.

Clinical educators should have appropriate personal characteristics that reflect a desire to teach and/or mentor a student clinician. Clinical educators should have the interpersonal and communication skills to facilitate supervisee self exploration and have a clear understanding of the needs and role of a student clinician. They should also have generational, cultural and diversity awareness as well as an appropriate level of sensitivity.

Quality clinical educators should be good mentors and teachers and have a desire to give back to the profession by assisting in the preparation of the next generation of audiologists and speech-language pathologists. They should create an environment of positive learning and interaction, have high levels of teaching excellence, and be respectful of students.

With regard to credentialing, participants in the Audiology Education Summits felt that quality clinical educators should hold licensure and/or registration when required by state law, have appropriate national certification, and have the highest degree level available when possible, making allowances for truly outstanding “master” clinicians when appropriate. Quality clinical educators should be active professionally and should belong to professional organizations and participate in professional activities and committees. They should have training in clinical supervision, be regarded highly in the professional community, and be considered life-long learners.

Lastly, quality clinical educators should be willing to provide feedback to the student and to the practicum site beginning with clear instructions provided by the program and continuing with a clear delineation of the needs and skills of the student. In addition, student self analysis and methods such as reflective journaling and chat rooms could serve as valuable tools for the development of problem solving and critical thinking, all of which are consistent with the

formative assessment process inherent in the 2005 and 2007 CFCC standards for certification.

Another source of evidence regarding characteristics of quality clinical educators can be found from the CAA/CFCC/CAPCSD survey sent to CAPCSD Clinic Directors in February 2005. Their data suggest some other qualifications include a record of success as a supervisor, specialty expertise, excellent interpersonal skills, at least two years in the current work setting, currency in the discipline and in supervision skills, and a good understanding of the university program philosophy and organization.

Merged Proposal of Quality Characteristics of Clinical Educators. Combining our proposal with evidence from the Audiology Education Summits and the CAPCSD Joint Committee Survey, we conclude that quality clinical educators should have the following traits. Clinical educators should have personal qualities commensurate with a desire, commitment, and passion for clinical teaching. Their professional reputation and ethics should be beyond reproach and, in regard to professional activity, extraordinary. They should have a clear understanding of the needs and expectations of students and the knowledge and skills for supervision in order to affect a successful practicum experience. In addition, training in supervision and experience as a clinical educator are essential. Lastly, clinical educators should hold appropriate national and state credentials.

Accountability and Ethical Issues

Quality clinical educators must be accountable at various levels (McCrea & Brasseur, 2003). They must ensure that clients receive appropriate services, that students receive an education that adequately prepares them for entry into the professions, and that the university program goals are achieved. They must uphold the standards and ethics of the professions and do so while balancing the students' need for certain experiences with the client's need for appropriate services. The training program must ensure that accountability measures are in place so that if a student's clinical education is ethically compromised in an off-campus placement, procedures are in place to support both the student, including alternative placement,

as well as the clinical site and its clinical education staff.

Conclusion

During the discussion at the end of this presentation, audience members suggested that they think it is important to revisit the idea of specialty certification in supervision. This is not a new concept; the 1978 ASHA Committee on Supervision identified the "need for special standards for supervisors, other than CCC" (ASHA, 1978). Currently, a few ASHA Special Interest Divisions (SIDs) have established Specialty Recognition. ASHA's Specialty Recognition program, which is completely voluntary, has been established for fluency disorders, swallowing and swallowing disorders, and child language. Audience members were overwhelmingly in favor of having SID 11, Administration and Supervision, pursue Specialty Recognition in Supervision and we think the time is definitely right!

References

Training in the Supervisory Process

- American Speech-Language-Hearing Association (1982). Committee on Supervision in Speech-Language Pathology and Audiology. Minimum qualifications for supervisors and suggested competencies for effective clinical supervision. *Asha*, 24, 339-342.
- Anderson, J. (Ed.). (1980). *Proceedings-Conference on Training in the Supervisory Process in Speech-Language Pathology and Audiology*. Bloomington, IN: Indiana University.
- Brasseur, J. (1984). The supervisory process: A continuum perspective. *Language, Speech and Hearing Services in the Schools*, 20, 274-295.
- Dowling, S. (1986). Supervisory training: Impetus for clinical supervision. *The Clinical Supervisor*, 4, 27-35.
- Dowling, S. (1993). Supervisory training, objective setting, and grade contingent performance. *Language, Speech, and Hearing Services in the Schools*, 24, 92-99.
- Dowling, S., & Biskyni, R. (1993). Effect of supervisory training and a practicum: A case study. In R. Gillam (Ed.), *The supervisor's forum*, 1, 9-12. Council of Supervisors in Speech-Language Pathology and Audiology.
- Dowling, S. (1995). Conference question usage: Impact of supervisory training. In R. Gillam (Ed.), *The supervisor's forum*, 2, 11-14. Council of Supervisors in Speech-Language Pathology and Audiology.
- Harris, H., Ludington, J., Roberts, J., Hooper, C., & Ringwalt, S. (1992). A documentation of the effectiveness of instruction in the supervisory process. In S. Dowling (Ed.), *Proceedings of the 1992 National Conference on Supervision-Total Quality Supervision: Effecting Optimal Performance*. (pp. 58-61). Council of Supervisors in Speech-Language Pathology and Audiology, Nashville, TN.
- Kelly, B., Davis, D., & Hegde, M. The supervisor and the student clinician. In *Clinical methods and practicum in audiology*. San Diego, CA: Singular Publishing Group, Inc.; 1994:77-92.

McCrea, E. (1990-1993). Doctoral Training Program in the Supervisory Process. Indiana University. USDOE Project # H-029D00066.

Smith, K. (Moderator). (1985). *Preparation and training models for the supervisory process*. Short course presented at the annual meeting of American Speech-Language-Hearing Association. Washington, D.C.

Tools to Support Supervisor Self-Reflection

Casey, P. (1985). *Supervisory skills self-assessment*. Whitewater: University of Wisconsin.

Casey, P., Smith, K., & Ulrich, S. (1988). *Self-supervision: A career tool for audiologists and speech-language pathologists*. (Clinical Series No. 10). Rockville, MD: National Student Speech and Hear Association.

Culatta, R., & Seltzer, H. (1976). *Content and sequence analysis of the supervisory session*. *ASHA*, 18, 8-12.

McCrea, E. (1980). Supervisee ability to self-explore and four facilitative dimensions of supervisor behavior in individual conferences in speech-language pathology (Doctoral Dissertation, 1980). *Dissertation Abstracts International*, 41, 2134B. (University Microfilms No. 80-29, 239).

Smith, K. (1980). Multidimensional Observational System for the Analysis of Interactions in Clinical Supervision (MOSAICS). In J. Anderson (Ed.), *Proceedings-Conference on Training in the Supervisory Process in Speech-Language Pathology and audiology*. Bloomington, IN: Indiana University.

Smith, K., & Anderson, J. (1982). Development and validation of an individual supervisory conference rating scale for use in speech-language pathology. *Journal of Speech and Hearing Research*, 25, 252-261.

Underwood, J. (1979). *Underwood category system*. Unpublished manuscript. University of Northern Colorado, Greeley.

General References

American Speech and Hearing Association (1978) Committee on Supervision in Speech-

Language Pathology and Audiology. Current status of supervision of speech-language pathology and audiology {Special report}. *ASHA*, 20, 478-486.

American Speech-Language-Hearing Association. (1985). Committee on Supervision in Speech-Language Pathology and Audiology. Clinical supervision in speech-language pathology and audiology: A position statement. *ASHA*, 27, 57-60.

ASHA Council for Clinical Certification (CFCC) Certification and Membership Handbook (2005). http://www.asha.org/about/membership-certification/handbooks/slp/slp_standards.htm

ASHA Council for Clinical Certification (CFCC) Certification and Membership Handbook (2007). http://www.asha.org/about/membership-certification/handbooks/aud/aud_standards.htm

Audiology Education Summit: A Collaborative Approach. September (2005). Conference Report co-sponsored by the American Speech-Language-Hearing Association, Council of Academic Accreditation in Audiology and Speech-Language Pathology, and the Council of Academic Programs in Communication Sciences and Disorders.

Audiology Education Summit II: Strengthening Partnerships in Clinical Education. February (2006). Preliminary report co-sponsored by the American Speech-Language-Hearing Association, Council of Academic Accreditation in Audiology and Speech-Language Pathology, the American Academy of Audiology, and the Council of Academic Programs in Communication Sciences and Disorders.

CAPCSD/CAA/CFCC Joint Ad Hoc Committee on Supervisor Qualifications (2005). [CAPCSD clinic directors responses to questionnaire on supervisor qualifications]. Unpublished raw data.

McCrea, E., & Brasseur, J. (2003). *The supervisory process in speech-language pathology and audiology*. Boston: Allyn and Bacon.