

Position Statement

Clinical Education **The importance and value for the** **speech pathology profession**

Copyright © 2005 The Speech Pathology Association of Australia Limited

Disclaimer: To the best of The Speech Pathology Association of Australia Limited's ("the Association") knowledge, this information is valid at the time of publication. The Association makes no warranty or representation in relation to the content or accuracy of the material in this publication. The Association expressly disclaims any and all liability (including liability for negligence) in respect of use of the information provided. The Association recommends you seek independent professional advice prior to making any decision involving matters outlined in this publication.



Position Statement

Speech Pathology Australia (the Association) recognises the critical importance of clinical education to the ongoing viability of the profession. The Association views student supervision as a professional responsibility and strongly encourages members of the profession to embrace the benefits of student supervision in terms of the development, expansion and indeed the future viability of the profession.

Current Issues in Clinical Education

Clinical placements provide students with the opportunity to develop clinical skills and awareness, skills in reflection and self-evaluation, as well as the opportunity to enhance interpersonal skills with clients and colleagues. In addition, clinical teaching aims to clarify the role of the speech pathologist in different settings (Royal College of Speech Language Therapists, 2003). Despite recognition of the importance of clinical education to the profession however, universities and the profession are finding it increasingly difficult to meet the clinical education needs of students. There are a number of complex factors that may be contributing to this.

To meet accreditation requirements as stipulated by Speech Pathology Australia, universities must demonstrate that their clinical education programs provide students with the appropriate level of education and training to meet Entry Level competencies as outlined in CBOS (2001). Whilst CBOS (2001) does not specify a specific number of clinical hours that must be undertaken in clinical training, it does outline the minimum skills, knowledge base and attitudes for entry level practice to the profession. It is unclear whether accreditation requirements are placing unnecessary demands on clinicians and universities but evaluation has demonstrated that graduating students from accredited courses are demonstrating the necessary competencies of an entry level practitioner.

Changes in speech pathology service provision and scope of practice have significantly impacted upon clinical placements for speech pathology students, particularly in settings for adult clients. Clinicians are required to see more clients than ever before, often for example in health settings, where patients are acutely unwell. There is a demand for a shorter length of hospital stay, thereby not only increasing workload demands upon clinicians but also impacting upon student opportunities to participate in patient care. Similarly, as outpatient clinics for some client groups have been discontinued in the public health sector (particularly in the domains of fluency and voice), clinicians are finding it increasingly difficult to provide adequate clinical exposure to these groups and students are finding it difficult to meet competency standards for these CBOS (2001) range indicators.

The traditional role of the speech pathologist has expanded to include interdisciplinary liaison and communication, plus the expectation to fulfil a range of generic tasks, including that of management (McAllister, 2005). Clinicians may be concerned that not only are they unable to provide the scope of clinical experience now required of new graduates, but they do not have the time or resources to devote to these areas.

Increased specialisation of the profession in areas such as head and neck surgery, ventilator dependency, cochlear implant and HIV/AIDS (for example) has increased the difficulties in providing student placements. Clinicians may feel they are unable to offer the range of learning objectives required within clinical placements, and may have concerns regarding patient fragility and confidentiality (McAllister, 2005).

The broadening of roles within the profession and the need to incorporate evidence based practice and research into clinical practice has also increased workload demand for clinicians. Coupled with staff shortages and difficulties with recruitment and retention of staff, clinicians may find it challenging to meet the time demands they see as inherent in student supervision.

The current Department of Education, Science and Training (DEST) funding model does not recognise the diverse nature of clinical placements in speech pathology or allied health in general, nor does it

provide direct funding for them. As such, universities must organise student training programs within a restricted budget and many are unable to provide any form of financial incentive or support for facilities taking students. Coupled with increasing student numbers, the pressure on external clinics becomes significant.

There may also be an unsubstantiated belief among health system managers that students are a drain on resources, and there is no obligation to take them (Health Professionals Council of Australia, 2004).

Speech Pathology Australia Position

Clinical education is within the scope of speech pathology practice; speech pathologists “conduct service management activities such as.....human resource management, including supervision of speech pathology students and colleagues, mentoring and recruitment” and “(speech pathologists) are involved in the education of others” (Scope of Practice, 2003). Speech pathologists “are encouraged to contribute to the provision of clinical education and clinical placement for entry level and post graduate level speech pathology students, work experience students and students of other health disciplines” (Principles of Practice, 2001).

At a time when there are ongoing changes to service delivery and associated fiscal constraints, Speech Pathology Australia believes it timely to promote the benefits of clinical education to members of the profession. For supervising clinicians, clinical education provides the opportunity to “contribute to the development and expansion of (the) profession” (Code of Ethics, 2000). Student supervision assists clinicians to stay abreast of innovations in speech pathology practice and provides the opportunity for critical evaluation of current standards of practice.

Students help develop a therapist’s reflective practice. The Association recognises this as contributing to a therapist’s continuing professional development, and as such it is acknowledged through the Association’s Professional Self Regulation Program (2003), whereby clinicians are able to accrue points for students they supervise on clinical placements.

Student supervision establishes and maintains links with universities and academia and provides opportunities for joint research initiatives. Honorary affiliation is offered to clinicians by some universities as acknowledgement of the contribution made to student training programs, providing access for the clinician to library facilities and the opportunity to contribute to the appraisal and development of student training programs.

The opportunity to improve the recruitment and retention of new graduates may be facilitated through supervision of students. In particular, placements in rural and remote areas may go some way to addressing the critical shortage of speech pathologists in these areas. Two of the best predictors of whether new graduates will work in rural areas are a rural background and a positive exposure to rural practice early in their training (National Allied Health Alliance, 2004). Rural placements that are well supported would promote the diversity and range of practice settings, provide the opportunity to work within multidisciplinary teams, and contribute to the development of both generalist and specialist skills.

The presence of senior students has been shown to increase productivity, through increased hours of direct patient care and the “freeing up” of clinicians to pursue other clinical and work related activities (Ladyshevsky and Barrie, 1996; Bristow and Hagler, 1997; Dupont, Gauthier-Gagnon, Roy et al, 1997). The presence of senior students has also been shown to increase revenue in private practice (Coulson, Woeckel, Copenhaver et al, 1991).

Strategies under Consideration

Speech Pathology Australia acknowledges the necessity for substantial change to the clinical education component of the student training program. A number of initiatives are currently being considered by the Association and key stakeholders. These include evaluating clinical education

requirements against accreditation and Entry Level CBOS (2001) requirements, and considering different models for, and new innovations in, the provision of clinical education. As described in the attached document prepared by Ferguson (2005), there are a variety of options or models for the provision of student supervision in a range of innovative settings. Other initiatives include increasing financial and educational support for clinical educators and addressing the current gross under funding of clinical education at a national level.

Regardless of the number and type of initiatives embraced by the profession, it is apparent that coordinated, open discussion must be undertaken at a national level involving key stakeholders in universities, government departments and the Association (Rose, 2005). It is essential that the profession continues to attract and retain those individuals committed to achieving excellence in speech pathology, and that their experiences as students equip them to deliver high quality, evidence based services that reflect best practice (Royal College of Speech and Language Therapists, 2003). Speech Pathology Australia remains committed to ensuring adequate clinical education opportunities are made available to all students in contexts that best reflect the diversity and challenge of the modern workplace.

References

- Bristow D & Hagler P (1997) Comparison of individual physical therapists' productivity to that of combined physical therapist-student pairs. *Physiotherapy Canada*, Winter, 16-23, & 31.
- Dupont L, Gauthier-Gagnon C, Roy R & Lamourex M (1997) Group supervision and productivity: From myth to reality. *Journal of Physical Therapy Education*, 11, 2, 31-37.
- Health Professions Council of Australia - HPCA (2004). *Solving the crisis in clinical education for Australia's health professions – A discussion paper*
- Ferguson, A (2005). Speech Pathology Australia and Heads of Speech Pathology Programs Discussion Paper. Models of Clinical Education – Towards Innovation
- Ladyshevsky R, Bird N, Finney J (1994). The impact on departmental productivity during physical therapy student placements: An investigation of outpatient physical therapy services. *Physiotherapy Canada*, 46, 89-93.
- McAllister, L (2005). Issues and innovations in clinical education. *Advances in Speech-Language Pathology* Sept 7(3): 138-148
- National Allied Health Alliance Inc (2004). *Under pressure and under valued: allied health professionals in rural and remote areas – Position Paper*
- Rose, M (2005). The cycle of crisis in clinical education: Why national – level strategies must be prioritised. *Advances in Speech-Language Pathology* Sept 7(3): 158-161
- Royal College of Speech Language Therapists (2003). The provision of clinical placements: Stakeholder roles and responsibilities – Position Paper
- Speech Pathology Australia (2003). *Professional Self Regulation (PSR)*.
- Speech Pathology Australia (2003). *Scope of Practice - Position Paper*
- Speech Pathology Australia (2001). *Principles of Practice - Position Paper*
- Speech Pathology Australia (2001). *Competency-Based Occupational Standards (CBOS) for Speech Pathologists Entry Level (2001)*
- Speech Pathology Australia (2000). *Code of Ethics*

Attachment 1

Speech Pathology Australia & Heads of Speech Pathology Programs

Models of Clinical Education – Towards Innovation

Author: Assoc Prof. Alison Ferguson, Speech Pathology Discipline Convenor and Program Coordinator, School of Language and Media, University of Newcastle on behalf, Heads of Speech Pathology Programs group.

As discussed in the Speech Pathology Australia position statement, clinical education in speech pathology is provided through a diversity of types of clinical placements. Speech Pathology Australia and speech pathology programs nationally are considering different models for, and new innovations in, the provision of clinical education. The term 'model' is usually used loosely, encompassing both explanatory theories of how learning may be facilitated as well as descriptions of exemplars of ways in which clinical education is provided. In speech pathology, the term 'clinical' education is generally recognised to cover all practicum experience, whether that takes place within a medical, educational or community paradigms, and is typically treated as synonymous with terms such as 'field placement' or 'professional experience' – naturally, choices between these terms tend to imply diverse theoretical positions with regard to models of education. For a detailed discussion of the main models of clinical education, refer to McLeod et al (1997)¹ in which the published models are reviewed within groups of described as 'descriptive' (e.g. describing the theories and processes), 'integration' (e.g. bridging between academic and clinical education), developmental (e.g. relating to stages of learning), interactive process (e.g. focussing on student-supervisor conferencing), and collaborative (e.g. peer learning), with a further 'teacher-manager' model being proposed by the authors. This paper suggests that the choices we make in selecting different aspects of clinical education provide a means to shape innovation and responsiveness to future education needs.

The key dimensions of the different models of education are often implicitly assumed to meld particular learning theories with particular ways of procedural implementation. To take two extreme examples (see Table 1), it is typically an implicit assumption that classroom learning is necessarily providing teacher-directed or didactic learning, in a ratio of one educator to many students, while clinical experience is providing experiential learning with a ratio of fewer students to the educator.

Table 1: An example of theory & implementation associations

<i>Method</i>	<i>Model</i>	
	Teacher-directed/didactic	Client-centred/experiential
Educator/student processes	One to many	One to some
Locations	Classroom	Clinic

However, innovation emerges from the judicious selection from key dimensions in order to achieve particular educational goals. So, to follow the examples provided in Table 1, an educator in a classroom setting may use recorded material and role-play to provide experiential clinical learning amongst peers while making detailed observations of individual students in order to provide one to one written feedback. Or, perhaps an educator in a clinic setting might identify that all the students involved in, say, a specialist placement may benefit from a lecture-style presentation in order to ensure a greater standardisation of learning of particular knowledge.

Table 2 provides a map of some of the key dimensions involved across different models of education, described here as aspects of the context of clinical education. Some of these dimensions can be argued to represent continua, in which there may be 'more' or 'less' of some features, while others are more clearly represented as discrete choices. In this map, the dimensions have been grouped for the

¹ McLeod, S., Romanini, J., Cohn, E.S., and Higgs, J. (1997). Models and roles in clinical education. In L. McAllister, M. Lincoln, S., McLeod, & D. Maloney (Eds.), *Facilitating learning in clinical settings* (ch.2, pp.27-64). Cheltenham: Stanley Thornes Publishers.

purposes of description into the 'what' of clinical education comprising both the theoretical paradigms of clinical education as well as the actual subject matter for learning, the 'who' comprising the interpersonal aspects of clinical education, and the 'how' comprising some of the logistical dimensions of clinical education.

Table 2: Aspects of the Context of Clinical Education

		Aspect			
What	Paradigms	Didactic	Experiential	Reflective	
		Teacher-directed	Client-centred	Student-centred	
	Processes	Lecturing	Participating	Conferencing	
		Cognition	Situated cognition	Critical thinking	
		Learning knowledge	Learning skills	Learning to learn	
	Learning opportunities	Specialised population	←→	Generalist population	
		Specialised skill	←→	Generic skill	
		Profession-specific	←→	Interdisciplinary	
		CBOS1-4	CBOS 5, 6	CBOS7	
	Location	Metropolitan	Regional	Rural	
	Institutional setting	Classroom	Hospital	Community/Education	
	Who	Relationship with 'community of practice'	Apprentice	←→	Collegial
			Recipient	←→	Contributor
			←→		
		Novice		Entry-level	
Educator:student ratio		One to many	One to some	One to one	
Educator		Academic	Clinical expert	Peer	
Client/student relationship		Distant	←→	Close	
How	Nature of experience	Observation	Participant	Clinician	
	Channel	Recorded	Simulated	Live	

These aspects of the context of clinical education provide a set of choices from which we can select to meet diverse educational goals. So, for example, we can deliberately break the nexus between institutional setting, learner stage and the nature of experience, through the inclusion of people with communication disorders working as tutors with small groups of students in which novices in a classroom setting obtain direct 'live' participatory experience in a small group setting². As an alternative example, we can use didactic teaching delivered by expert clinicians to students using recorded and simulated learning activities³.

² Beecham, R. (2005). "Clients" as teachers: Power-sharing in the speech-language therapy curriculum. *Advances in Speech-Language Pathology*, 7 (3), 130-137.

³ Rosza, M. (2002). Introducing speech pathology students to the world of specialty speech pathology practice. In C. Williams, & S. Leitaio (Eds), *Journey from the Centre: Proceedings of the 2002 Speech Pathology Australia national conference* (pp.213-221). Melbourne: Speech Pathology Australia

Diversity of experience in itself, although useful in providing alternative learning opportunities for learners and education providers, is not a sufficient end in itself. Such an approach to making use of the resources that exist in the context of clinical education needs to be explicitly linked to the academic curriculum and to the attainment of the competency-based occupational standards for the entry-level speech pathologist⁴.

⁴ For further reading in this area, see Brumfitt, S. (Ed.) (2004). *Innovations in professional education in speech and language therapy*. London: Whurr; and, McAllister, L. (2005). Issues and innovations in clinical education. *Advances in Speech-Language Pathology*, 7 (3), 138-148.