Clinical Education - A fundamental curricular unit for all health practitioners

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ABSTRACT

Clinical education is recognized as being crucial for the training of health professionals. This subject is debated amongst teachers, students and professionals. Besides the clinical and research skills, we look for other competencies such as oratory, creative thinking or leadership.

We present the results of a study with 4th graders. It's a exploratory study; the main purpose was to evaluate the outcomes of a unit of clinical education prepared according a new set of competencies and methodologies.

The competencies were seen as valuable. Organization, leading or supporting a colleague, rethinking a program to serve client and family are equally important.

Kea-words: clinical education; high education; health professions, speech therapy.

RESUMO

A educação clínica é reconhecida como uma unidade crucial na formação dos profissionais de saúde. Este assunto tem sido debatido por professores, alunos e profissionais. Além das competências clínicas e de investigação, procuram-se agora outras: a oratória, pensamento critico e criativo ou a liderança.

Apresentamos os resultados de um estudo com alunos finalistas. É um estudo cujo objectivo principal pretendia avaliar os resultados da unidade duma educação clínica preparada segundo um conjunto determinado de competências e metodologias.

As competências e metodologias foram consideradas válidas. Organização, liderança, o repensar um programa para servir utente e família foram vistas como igualmente importantes.

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Kea-words: Educação Clínica; ensino superior; profissões da saúde, terapia da fala.

1. INTRODUCTION

Speech-Language Therapy (SLT) is one of the eighteen allied health professions existing in Portugal. (Decreto-Lei 564/99).The first courses in the field are from the 1960 decade, but they only expanded in Portugal this last ten years with the integration in the Ministry of Education and were recognized as superior degree, that is, when research in the field really started.

The curriculum has always been of major concern and object of research in itself by all European professional agencies. For SLTs in Europe, CPLOL[1] has a reference group for discuss such matters since 1985. In each country, and for the allied health professions, there has been a close contact between the professional and the academic world, in order of better adequacy or the curricula from the clinical point of view. And all the curricula were planned to serve the needs of such professionals – good clinicians, eventually, good managers, if they choose an administrative career.

Clinical Education has always been a major concern for all health professions (Stengelhofen, 1993; McAllister and Lincoln, 2004). It's the moment students meet face-to-face with a real-life patient and is recognized as being crucial for the training of any health professional. It is mandatory for many professions but actually, it should be mandatory for every professional who has to contact with a person that is or feels unwell, or has a relative that needs health care treatment.

The deliberate process of curricula transformation, in order to accommodate new competences more related to what is expected from a health professional is not new. It occurred all over the world and new methods have been described "... emphasizing problem based learning, information technology, new curriculum goals, new teaching strategies (some in clinical settings)..." (Murti and Sefton 2000). This authors referred in their study that many patients were willing to contribute to the education of future doctors and valued better communication, their autonomy to be respected and undue distress avoided. Similarly, hospital managers demanded commitment, knowledge and clinical slills, as well as familiarity with the requirements of hospital practice. Those generic skills, are good communication skills, self awareness and teamwork as well as professional and ethical behaviours.

The Escola Superior de Tecnologia da Saúde do Porto (ESTSP-IPP), in the last curricula reformation also changed its policy for defining the curricula for all the thirteen courses, defining all of them as competence based instead of discipline based as it was before. It started with a major debate, national wide between schools teaching each degree where ESTSP-IPP participated and professionals in the field were also present for establishing a target profile for each profession (Lopes, 2004). During this process, advanced teaching methodologies were discussed, international agencies (both for high education such as QAA or Tuning project and in each specific field i.e. ASHA for Speech and Language pathology in the EUA) were consulted and employer entities inquired (EUA, 2004), in order to adjust the profile and the methodologies to better serve the necessities of the community we intend to serve. Two major assets called our attention:

- The interpersonal and systemic competencies should be equally addressed, as well as the clinical competences, explicitly, in the curriculum ;
- The units related to clinical education were under rated in the previous curricula. The profile of the health professional was much more demanding nowadays and working only towards clinical competences was insufficient to prepare the new professional for what were the requirements of the market (CPLOL, 2007).

The new curriculum, to be implemented in 2008-2009, took these guidelines into account and was designed accordingly. Our main objective, for this study, is to present the changes felt in the students of the fourth grade of the speech therapy course during 2009-2010. Besides the clinical competencies, mandatory for all students in their final year, there were a set of other competences such as creative and critical thinking, team work, oral and written report, leadership, planning, organizing, time management, related with other roles a health professional can be called to perform (CPLOL, 2009).

We also wanted in some way to serve the community who surrounded us. The first contacts with the local entities had shown us there were needs we could meet and our students could benefit from the

[1] CPLOL – Comité Permanent de Liaison Orthophoniste/Logopèdes de L'Union Europeéne

contact with the local population, due to its diversity in age, culture and needs. Protocols were signed, collaboration was on the way.

The preparation started the year before, where some of the basic knowledge were introduced. There was two unit where student could practice collecting data, case discussion amongst peers, reporting, oral and in writing, comment competences for teamwork, for instance. This unit should be both theoretical and practical and should help the student to reflect over their own learning experiences. The main goal was to make the student responsible for his/her learning process.

Before this study started, we had a meeting with our colleagues that have been helping us with clinical education. We wanted to share with them the new curriculum and learn from them what are the new expectation for the new professionals in the field. The general view is that professionals that work in the clinical placements are responsible for teaching and guiding the students in real life situations. University teaches about the theory behind the techniques and specific knowledge and how to progress into scientific investigation or ethical behaviour.

Our colleagues told us that besides the clinical and research skills in the field, mandatory to all graduates, there is a search for other competencies such as oratory, creative thinking, management or leadership.

This new competencies demand more from them, as supervisors at clinical placements. This fact originated new discussions between ESTSP-IPP teachers and the community where the clinical placements occur, since clinical supervisors feel they don't have the necessary level of expertise to teach those competences, have their own challenges in their carriers and don't have the time to study or to accompany the students.

A new meeting between the teachers who would be involved in these new units occurred, to discuss these new findings. Everyone felt as very important to give the students the opportunity to experiment as many roles as possible, in accordance to those they would be call to perform in the future. So, following Ducey's indications (2009) that each student should also be somewhat responsible for his/her learning process, it was agreed that the field of activities would be extended to give students the opportunities to practice other competences. They would have to plane their own timetable, propose a prevention activity for the community, or any other activity thought adequate to the community at the moment. They would have to plan it, organize it, care it through and them, evaluate it, reflecting on the outcomes. Resources had to be carefully calculated and applied for as well. Institutions had to be contacted. Letters had to be written. And the all process had to be reflected upon by each student as a learning process – what am I learning from this?

This process was closely followed by weekly meeting where teachers and students debated their progresses and weekly registrations as well.

The study we are about to describe occurred during this scholar year and involved teachers and students from the 4th year of the speech therapy course and was negotiated between all the involved. It is an exploratory study and it is our aim to share with you the results we accomplished. We also pretend to validate the ESTSP as a clinical placement for clinical education.

Aldo there is many literature about clinical education, and specific literature about speech therapy, we didn't find any regarding the interpersonal or systemic competencies growth in these contexts. So, it was all also a reflexive process for the teachers involved as clinical educators, who kept their own diaries, notes and weekly meetings, to accompany the students in their process. As McAllister and Lincoln (2004) say, "...personal as well as professional growth should be expected as outcomes both for the student and clinical educator...".

2. Methodology

This is a exploratory longitudinal study, with two main goals:

1 – Validate ESTSP-IPP as a clinical placement for clinical education for 4th graders;

2 – Evaluate the outcomes of a new unit of clinical education prepared according a new set of competencies and methodologies.

2.1 Population

All the 4th graders were involved in this study. They were 36 in the beginning of the scholar year. It was our intention to enrol as many students as possible in order to take as many feedback as possible as well. The students were consulted at the end of the previous year to see if they would be willing to participate in this programme. There were no objections from any student at any point.

2.2 Instruments

There was already a scale to assess clinical and interpersonal competences regarding the patient and his/her family and other professionals and it assessed each set of competences separately. Systemic competencies were embedded in clinical competences regarding planning the intervention where family should be included, for instance.

A weekly registration was also mandatory, for clinical assignments, activities, and for accompany the reflexive process.

At the end of the unit there would be a port folio where the student could put together the pieces he/she thought were most representative of his/her learning process.

Both the scales and the portfolio were graded by the clinical educators on a scale from 0-20. The weekly reports were commented and given feedback on a weekly base as well as graded qualitatively.

2.3 Procedings

The programme started as planned in October 2009 with the first group of 14 students. Two other groups followed, one in January and a third one in April. They all attended a ten week period of clinical education in the same conditions.

At the beginning of the unit, clinical educator and student would meet to share the materials available (scales, list of competencies to be met, contents, cases, ...) expectations, methodologies to be followed, to know the group.

There would always be a group of eleven to fourteen students involved. In this first meeting, they were assigned into one of three sub-groups: one for addressing children´s language and communication problems and two for adults speech problems.

They were told they would have to arrange their own timetable in order to accommodate meetings with their supervisor timetable, caseload assigned, propose at least one activity and try to define their own goals for the first half of the clinical practice. The functioning of the service would be similar to any other service of speech therapy so, any requirements should be made through each supervisor.

General organization of the clinical planning would be first week observation; 2nd to 5th week planning and start to implement interventions; 6th to 9th week rethinking intervention and/or continuing intervention; other activities; 10th week evaluation and goodbyes.

Since all the procedures were fully understood, some further ruling procedures were instated: There would be an appointed secretary for each meeting for recording each meeting. Each written report would be sent to all participants for approval and later on for registration on a record of the evolution of the work been done or decisions taken. A chain of communication was establish to get from the main group to each sub group.

All data were recorded either in record sheets by each sub group when related to sub group activities or in the written reports. Each student had to report to his/her clinical educator to individual monitoring with an individual record sheet where he/she would report his/her reflections on learning experiences and proposals for learning in the next week. Each clinical educator was suppose to give written and oral feedback to each student, either individually or in the sub group as chosen by the students.

Strategies such as task analysis, peer tutoring, modelling, praising the behaviour closer to the target, critico-creative and reflexive thinking were used ((Fisher, 2009).

3. RESULTS

Due to health conditions, two of them did not participate in this study so, only 34 of our student enrolled in our programme. There were initially three clinical educators thought to be involved but soon the team perceived as necessary to have a backup for each so the teacher team duplicated almost from the very beginning.

After the first meeting and being distributed by the sub-groups, students studied the caseload assigned, even they didn't know with case they would be working directly with. Cases were organized into individual files and were incomplete as a rule so, when planning the time table, some time should be thought to study the cases and plan the data to be collected. The time table for each case were supplied so students could attend the appointments but only two at the time, according to the availability stated by the clients2.

Students learned to organize themselves in two by two and their timetables accommodated both their needs to work as a sub-group, to work with the other sub groups and also with the clinical educators and the clients. They became extremely organized in time, planning ahead, and demanding from each other the same organization. This was felt either in the process of the clients but also in the organization of an activity, where planning ahead involving others, leading a team were words that got a new meaning.

Positive results were also felt in the ability of reflecting on their own practice and on criticizing each other on a constructive way, actually helping each other. The two by two teams worked better since students used it to positively criticize and improve each others' reports, in each sub-group and between sub-groups. This was not proposed by clinical educators but was thought as a measure to improve their own results by students themselves, since they were working in different areas of knowledge.

Some of the students were involved in peer-tutoring for younger students (first and second graders). This was one of the activities proposed: to lecture/to prepare a case to present to a class). The feedback was extraordinary since the students plan the case carefully, including the information to live off, how to respond to doubts, how to grade students responses and participation and how to encourage problem solving. That is to say, they understood the method and adapted it to a new situation.

Some of the students also reported the advantages of the enlargement of the discussions of the cases with other professionals, such as Occupational Therapists, Physiotherapists, Teachers and Psychologists and how important it was to have a global understanding of the person and family for a better intervention.

All the three groups proposed some activities concerning several areas of speech and Language Therapy. All the students reported at some point improved skills in planning and organization, leading and helping, managing and the importance of teamwork and managing conflicts for the success of any project.

The meeting at week five where intermediate evaluation took place was considerate especially important by all students since they could redefine their own goals and strategies and ask for help from their peers in pursuing their goals. This was particularly felt in the last groups, who engaged in a dynamic of interaction and peer-tutoring, surpassing all.

The assessment meetings, both the intermediate and final assessment were generally held in group, since students felt they could learn much more been all present and also be supportive for each other if necessary. The process involved only each sub group at the time with their clinical educator. At the intermediate student was told the base line and was discussed ways to improve. He/she proposed a programme to improve (self-determined programme). At week ten the programme was evaluated as well as the global results, if the group helped as they said they would and the clinical educator should see if he/she played his/her part. The results were measured accordingly.

We also demanded, in the end of the scholar year, some feedback from the clients of the services delivered. The feedback was positive and there is a waiting list for next year already.

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[2] Clients were other teachers or students from ESTSP-IPP who volunteered to participate in this programme for speech. They were fully aware of the conditions and signed a declaration stating so. For language and communication, there was a primary school, with kindergarden. After authorization from parents and teachers, a screening test was conducted. Children considered in need for therapy were them enrolled after parental consent.

The written reports have been sent to local authorities or other entities who are now recognizing us as a local service for speech and language therapy.

4. DISCUSSION

Considering the results, we can say that both goals have been met. Regarding the first one, it was a new experience, both for clients, students and clinical educators. The service provided met the requirements needed to be considered for the students and clinical educators as a clinical placement for a curricular unit of Clinical Education for Speech and Language Therapy. There is a sufficient caseload and workload to challenge a student or group of students and to develop all the competences previewed in the curriculum for the unit.

The methods used were adequate to the groups attending the curricular unit but had to be improved along the scholar year. The procedures were improved due to the feedback given by the students who helped us to prepare for the following groups with their reflections and their critiques. Working in pairs, for instance, was seen as a very good strategy if used to help the other to reflect on the strategies, planning, and not only as a way to improve registration. The clinical educator has to adequate his/her monitoring to the student, his development, so he/she can find by himself the solutions. Finding the right pair seems like an important decision for a clinical educator at this point, as will be finding the right sub-group into the group. This involve competences of group dynamics as well for the clinical educator and a strong sense of his/herself and of what really matter from the professional point of view (McAllister and Lincoln, 2004). As the authors stated, it takes an skilled clinical educator to follow this process, giving the right amount of information the student need to fulfil the process but never to much that will prevent him/her from thinking it through.

The liberty given to scheduling their own timetable gave the group a greater responsibility in organization and managing of the agenda. Actually, there was a lot to consider. A chain of command was establish from time to time (on a weekly basis) so there was someone in charge and nothing failed. Papers were assigned in each subgroup for contact, participation in meetings according to different tasks or goals to achive. Competencies of leadership were stronger in some of the elements of the group but, when detected in the intermediate meeting, the others established it as their personal goal and ask for help so they could also improve those competences, at least, in part.

Competences such as critico-creative thinking was thought as fundamental for the process. Rethinking was also found as very important. Deconstruction and reconstruction became an habit, such as task analysis. Students were now asking “how can we do better?”.

Meetings were planned and the plan was completed in time. Discourse, oral or written improved, becoming more focused, simple, hence, time saving. The final portfolios are well the mirror image of this. Smaller them all the others, more focused, they all focus learning processes in different opportunities either related to cases, discussions with the clinical educator, teamwork with other professionals or organization of a project, regardless of the outcomes.

This «new» competencies were seen as valuable by the students who find themselves better prepared to face the professional. In the previous years, when we asked where they expected to be in five or ten years, the answer was always performing as a speech therapist, in a clinical role.

These students, in their final reflections in their portfolios, refer they felt they could participate later on as clinical educators or teacher and they felt a responsibility to do so, they felt more able to manage their own department or help a colleague to do so.

They also felt as very useful to define goals for themselves and said they would do it in the future. Defining intermediate timings to rethink a process, either for a client or for themselves was seen a productive way to see if thing were in the right track.

Finally, the role of the clinical educator was seen as of the outmost importance and the success of this unit depended also of the close follow up of all through diaries, registrations and weekly discussions. That is to say such a program requires a senior clinical educator fully prepared to adjust to each student needs at every moment, to support the group if one of the elements fail and to protect the client if necessary.

When considering all the competencies achieved by our students, we can say we fully accomplished our second goal of our study.

5. FINAL CONSIDERATIONS

Clinical education is a journey of growth and development for all. Competencies such as organizing and managing a department, leading or supporting a colleague, rethinking a clinical program to better serve a client and his/her family are equally important as a health professional. But the results surely surpassed the outcomes planned for this unit.

We cannot say with absolute certitude that the results are only due to what was planned and the methodology adopted and they should be confirmed with the results from students from the following years and also by the institutions where these ones find their professional placements. A follow-up study should also be considered to verify if those new practices were still used.

Anyhow, results were encouraging and made us believe that there is a need to further discussion in this area (clinical education) and what a university can provide as evidence for improvement in the field.

It also made us think of the need to approach the clinical setting to the academic and research ones. These fields should be working together, as it can be seen. They all support each other and produce knowledge to help improve the other. The students called our attention for the need of building bridges and create a net less formal between those groups.

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