Service Delivery and Student Clinical Education: Are the Two Compatible?

La prestation de services et la formation clinique des étudiants: sont-ils compatibles?

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Abstract

Clinical practicum is a significant and essential component of clinical education for speech-language pathologists and audiologists. Although many clinicians express interest in contributing to clinical education by supervising students, finding a sufficient number of practicum sites has often been a challenge. Concerns about recruitment and retention of supervisors may increase as the university programs expand. One source of this difficulty may be the perceived conflict between community demands for service delivery and university demands for clinical education. This article explores some of the issues involved in this controversy such as ambiguity about the supervisor's role and responsibilities, debate about the quality of care provided by students, individual and institutional costs associated with supervision, and the nature of the recognition accorded the clinical supervisor. The paper concludes with a call for efforts on the part of professional associations, universities, governments, and service agencies to resolve this situation.

Résumé

Le stage clinique est une partie importante et essentielle de la formation clinique des orthophonistes et des audiologistes. Malgré l'intérêt manifesté par plusieurs cliniciens pour la supervision des étudiants, les endroits où l'on peut faire des stages cliniques demeurent difficiles à trouver. A mesure que les programmes universitaires se développent, la question du recrutement et du maintien des superviseurs prend de l'ampleur. Une des origines possibles de ce problème pourrait être le conflit entre les exigences de la communauté pour la prestation de services et les exigences universitaires pour la formation clinique. Cet article aborde plusieurs des questions entourant cette contreverse, comme, par exemple, l'ambiguïté du rôle et des responsabilités du superviseur, le débat concernant la qualité des soins offerts par les étudiants, les coûts individuels et institutionnels associés à la supervision et la reconnaissance du rôle du superviseur. Il sera enfin question de la nécessité que les associations professionnelles, les universités et les agences et services gouvernementaux prennent des mesures pour résoudre cette situation.

In an effort to meet the growing demand for speech-language pathologists and audiologists in this country, a number of the Canadian university programmes will soon be increasing their enrolment, and one or more new programmes will be established. Such expansion obviously necessitates an increase in both the number of academic faculty to teach in these programmes and the number of clinical supervisors to provide practicum experiences. To meet the latter requirement, the universities and the profession face an interesting dilemma. How can the community provide sufficient practicum placements when there is such a shortage of qualified professionals? How can this shortage be alleviated if a sufficient number of professionals is not trained each year?

Although expansion of the Canadian programmes brings this issue of clinical practicum supervision to the forefront, it is certainly not a new dilemma. The selection and retention of practicum sites has been a topic of discussion at more than one meeting of the clinical coordinators in the Canadian university programmes. It is also an issue faced by other allied health professions. Skolnik (1988) reported in the results of a survey on Social Work field instruction in the United States that "how to find and keep persons able and willing to provide field instruction to students" (p.58) was the most frequently cited area of concern. A recent survey of Ontario health care and educational facilities conducted by the Faculty of Applied Health Sciences at the University of Western Ontario revealed that occupational therapists, physical therapists, audiologists, and speech-language pathologists have many common concerns related to student practica. Universities often find it difficult to place students, while clinics, with long waiting lists, insufficient staffing, and pressure to maintain a certain level of productivity and quality of patient care, find it difficult to accommodate student training needs. Clinics, especially in the six cities in which programmes are located, may feel that expectations from the university are high and hard to meet every term. On the other hand, the university programmes are caught short if particular clinics refuse to take students. Unfortunately, all of this leads to what appears to be a situation of incompatible needs between community demands for service delivery and university programme

demands for clinical education. There are a number of issues that contribute to this dichotomy and warrant consideration.

Responsibility for Clinical Education

Few would argue with the premise that one goal of clinical practicum is to provide an environment in which the student can apply theoretical academic knowledge to the assessment and treatment of communication disorders. What seems unclear is the place where the university's role ends and the practicum site's begins in the clinical preparation of students. Who is responsible for clinical education? As a clinical practicum coordinator, first in Nova Scotia and then in Ontario, I have had many opportunities to discuss this question with speech and hearing professionals. I often come away from discussions with supervisors with the feeling that they do not see their role as an integral, critical component of professional education. Supervisors may complain that students come to the site ill prepared for practicum, specifically, for work with a particular population, for managing a caseload, and for interacting with other professionals. University programmes try to deal with this by providing practicum preparation classes, labs associated with courses, and videotape or simulation experiences. The University of Western Ontario and the University of Alberta have on-site clinics in which students obtain initial practicum experiences. Nevertheless, supervisors request more extensive pre-practicum preparation and often insist on students with previous experience. One must wonder if they truly see themselves as clinical teachers, responsible for assisting the student in acquiring clinical skill. This is, of course, one responsibility of the supervisor. Who is in a better position to provide this clinical education than the experienced clinician?

In the United States, greater responsibility for clinical practicum appears to be assumed by the university, in that many programmes have an on-site clinic. Students tend to complete early practicum experiences in this on-site clinic and then may choose to complete an externship towards the end of their training (Ehrlich, Merten, Sweetman, & Arnold, 1983). In fact, one current requirement for the Certificate of Clinical Competence awarded by the American Speech-Language-Hearing Association (ASHA) is that the first 25 hours of practicum must be supervised by members of the university's professional staff. The new standards for the Certificates of Clinical Competence, to become effective in 1993, no longer list this requirement (*Asha*, 1989). In the spring of 1988, I had the opportunity to visit three American programmes with large on-site clinics — the University of Connecticut, Northwestern University, and Indiana University. I returned with a wealth of information and ideas about university clinics and practicum. I also returned feeling very positive about two aspects of clinical education in Canada that differ from education in the United States. The first is the reliance of the Canadian programmes on external clinics for much, if not all, of the practica. The second is the Canadian emphasis on intensive externship experiences. All Canadian programmes require at least one intensive two to four month placement; this may be only an option in some American programmes. I view both of these aspects of our system as strengths. Our students obtain experience with a wide variety of populations in a variety of settings. They also learn how to manage a caseload, complete administrative tasks, provide in-service education, and function as team members with professionals from other disciplines. Canadian graduates tend to be highly competent professionals, and this strength is due, in part, to the nature and high quality of their clinical practicum experiences.

If externship supervisors do not see themselves as critical members of the educational team, I wonder if this is due to the fact that they do not see clinical training as their responsibility or to the fact that they do not feel fully recognized and appreciated by the university. I will return to both of these points later.

Quality Of Patient Care

Is the quality of patient care compromised when students are involved? This is an issue of concern to clinic directors whose primary responsibility is quality service delivery. In an article summarizing discussions between representatives of both clinics and universities in Colorado, Ehrlich et al. (1983) presented the clinic view that "professional quality simply is not possible in a graduate student extern no matter how bright or how well trained he or she is because experience is too limited at that stage of career development" (p. 26). In discussing a "hands-off" approach to supervision, they say that "the professional clinic does not allow us the luxury of that approach because patient care is the first priority and mistakes should be avoided" (p. 26). This is a view expressed by many clinical supervisors with whom I have interacted, and the issue is one which I, as both a practicum coordinator and a coordinator of a service delivery clinic, have not yet resolved completely for myself. I do believe that a very high quality of care can be provided by students *if they are adequately supervised.* I suppose I adhere to the philosophy that "two heads are better than one" and that clients/patients benefit from the joint analysis and problem-solving that goes on between the supervisor and the student clinician. Student clinicians also devote considerable time, energy, and thought to the preparation of interesting, motivating, and effective treatment activities. In addition, students bring up-to-date research information from the classroom to the clinic, and the process of supervision provides a built-in mechanism for continuing education. Jean Anderson (1988) in addressing issues in off-campus practicum has an interesting response to the Ehrlich et al. (1983) comments reported above. She states:

"This argument is, of course, based on the assumption that supervisors never make mistakes" (p.264).

The Costs of Supervision

Each term as I call clinics to arrange student practica, I encounter two very different views concerning this issue. Some supervisors see supervision as a time consuming activity, while others view it as a way to lighten workloads and provide service to greater numbers of clients. There are some definite time savers in supervision; it is the student clinician, rather than the supervisor, who is preparing therapy materials and activities, making phone calls concerning the clients, and writing reports. There is, however, additional time required in supervision — time to read and correct lesson plans and reports, time to discuss the client, the assessment and therapy procedures, and the client's disorder, and time to conference about the student's performance.

Supervisors who take their role as clinical teacher seriously devote a great deal of time to this process. While both ASHA and the Canadian Accreditation of Service Programs Committee of the Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) have developed some minimal requirements for supervision (for example, direct observation of 25% of therapy sessions), it is difficult to adhere strictly to these guidelines. An over-supervised student may not develop the independent thinking required of a practising professional, while an under-supervised student may not learn appropriate clinical skills or may not develop good self-evaluation skills. Within our field, there is little objective data available concerning the time commitment involved in supervision of students. There is, however, some information available on this topic in the Occupational Therapy literature. Chung and Spelbring (1983) conducted a study of time involvement and costs to occupational therapy fieldwork agencies by analyzing logs completed by students and instructional staff during 12 week placements. They reported that agencies "typically incurred large 'losses' during the first 3 to 4 weeks, while gaining a substantial sum of 'benefits' for the remaining 8 to 9 week period" (p. 687). Supervisors spent a considerable amount of time orienting and instructing students during the early part of the practicum, but this was followed by a rapid increase in the number of hours students spent carrying out agency work and a rapid decrease in the number of hours spent by agency staff in student instruction. This trend has also been reported to me by supervisors in our field, who have indicated that the amount of work and time involved in supervising a student gradually decreases over the course of the placement. Chung and Spelbring (1983) reported another interesting, but not altogether surprising, finding: Smaller agencies have more difficulty than larger agencies absorbing student instructional needs, and they tend to schedule student activities to meet agency needs. Burkhardt (1985) described both tangible and intangible costs and benefits of an occupational therapy fieldwork program. In a study examining one tangible cost, the time spent by staff on the student program, and a tangible benefit, independent treatment by student, she determined that agency costs were essentially balanced by benefits. Burkhardt mentioned one intangible benefit of particular interest, "the reduction in the cost of staff recruitment and orientation" (p. 36). In citing the results of a Texas study concerning several different health science programs, she reported that "participatory personnel found that by employing former students, hospitals with clinical instruction programs were able to recruit higher-quality staff who required less orientation time" (p. 36). As the shortage of qualified professionals is one of the reasons for the expansion of the Canadian university programmes, employing agencies might keep this benefit in mind when the cost of providing clinical education seems prohibitive.

In our own field, Girolametto (personal communication, 1990) conducted an analysis of time allocated to supervisory conferences in the speech-language pathology department of a children's hospital. He determined that supervisors worked on the average an additional 10 minutes for every hour of student involvement. For example, in a 7-1/2 hour day, 75 minutes were devoted to supervisory conferences. This calculation did not include time devoted to reading lesson plans or reports, or time spent actually seeing a patient. Supervisors in that facility observed patient care for the most part 100% of the time, and consequently this additional time commitment was not offset by time gained if the student saw a patient without the supervisor present. This time was an average, with supervisors tending to spend more time at the beginning of the internship and less toward the end.

It is difficult to determine a standard or norm concerning the time investment of the clinical supervisor or community agency because there can be so much variability due to such factors as the nature of the practicum, the competence or independence of the student, and the style of the supervisor. Research is clearly needed on the actual costs of supervising speech-language pathology and audiology students.

Anyone who has supervised a student who is experiencing difficulty is well aware of the tremendous amount of time that can be involved. This leads to another point about supervision, which may often affect a clinician's decision to supervise, and that is, the impact of the supervisory process on the supervisor. One of my academic colleagues once described supervision as "dealing with fragile egos all day." Although supervision can be rewarding and stimulating, the process of providing feedback without arousing defensiveness and of balancing teaching with attempting to develop independent problem-solving skills in a student clinician can be draining.

Rosenfeld (1988) conducted a study using a questionnaire to examine factors related to turnover of Social Work field instructors. Over 60 percent of the respondents reported that supervising students resulted in additional workload. However, it appeared that the extra work was "not necessarily perceived as a burden by the field instructors" but "became troublesome when the actual experience with the student was not gratifying enough to make the exchange worthwhile" (p. 193). Perhaps supervisors sometimes lack the energy to engage in the supervisory relationship and feel that the supervisory role is unappreciated and undervalued by the students, the clinic administrators, and the university faculty.

Recognition of the Externship Supervisor's Role

There is no question that externship supervisors play a vital role in the education of audiologists and speech-language pathologists in Canada. How this should be recognized is an unresolved question. My discussions with many supervisors have revealed that they feel a lack of support from hospital, clinic, and school board administrators for engaging in clinical teaching activities. These organizations may identify clinical teaching as falling within their mandate, but there is little or no time allotted for supervision. Clinicians are expected to maintain heavy caseloads. The profession and the universities must lobby administrators and ministries of health, education, and social services to recognize the importance of clinical supervision.

Within the profession as a whole in Canada, the role and responsibilities of the clinical supervisor need to be defined. ASHA has taken steps in this regard, demonstrated by the publication in 1985 of the Position Statement on Clinical Supervision (Asha, 1985b). The Canadian Association of Occupational Therapists (CAOT) has in place a system for accrediting occupational therapy services as fieldwork sites. In order to become accredited, a service must achieve certain standards in such areas as staffing, policies and procedures, client care, and student supervision (CAOT, 1987). As for our field, one of the standards (standard 20) included in the Canadian Accreditation of Service Programs (CASP) manual concerns supervision of students. In the Introduction to *CASP*, the authors state: "We firmly believe that most programs will meet the standards and will be able to display proudly an accreditation certificate" (p. 1-2). It appears that supervision of students is considered by CASLPA to be a professional responsibility, although the main focus of the document and the accreditation process is the assurance of high quality clinical services. It is interesting to note that the Manitoba Speech and Hearing Association has developed, as part of its licensing program, requirements for the supervision of practising professionals new to that province. Employing agencies are informed of these regulations and are expected to provide time for supervision. In February, 1988 the clinical practicum coordinators in the seven Canadian university programmes met, at the request of the Council of Canadian University Programmes (CCUP), to discuss various issues related to clinical practicum. Included in the recommendations forwarded to CCUP was a statement concerning qualifications for supervisors. This statement outlined minimum requirements concerning professional standing and experience: a graduate degree in human communication disorders, and/or membership (or eligibility for membership) in the provincial association, and/or membership and certification by CASLPA, and at least one year of professional experience. Although these recommended requirements are quite general, their inclusion may be considered a first step in examining standards for supervisors. All of these developments indicate that requirements for supervisors have been given some initial consideration by both the professional associations and the universities.

The Canadian university programmes make some effort to recognize clinical supervisors by offering honorary appointments, special privileges, and continuing education. Whether further recognition is due is a source of controversy. Is student supervision the professional responsibility of practitioners in speech, language, and hearing, or is it an added duty for which they should be reimbursed? I believe that supervision is my professional responsibility and that there are many benefits inherent in the process. Such benefits include the stimulation of working with a keen and inquisitive student, the satisfaction of sharing my experience, and the opportunity to stay current in the field. However, Ehrlich et al. (1983) raise a thought provoking question when discussing this issue. In citing the point of view expressed by the clinic representatives they state: "We are baffled by the contradiction that universities should be reimbursed for training but hospitals or other clinical organizations should not. By what logic should one receive tuition or payments for training, while the others give it away?" (p. 27). When one considers that Canadian students typically have engaged in about 300 hours of client contact by the time they have graduated, it becomes apparent that community agencies are responsible for providing a significant percentage of the education these students receive. At a time when many clinics are struggling to provide service, additional funding to cover student training would no doubt be most welcome. I recently learned that in London, Ontario community physicians receive a stipend for supervising students from the Family Medicine programme at the University of Western Ontario. Similarly, the Faculty of Education pays stipends for practice teaching placements and the Department of Psychology reimburses practitioners differentially according to the nature of the practicum experience. How is it that Medicine, Education, and Psychology can find funding to support the practical components of their programmes while the professions of Speech-Language Pathology and Audiology have no such funding available

to them? If, in fact, teaching hospitals receive funding for clinical supervision of all health care professionals, then it appears that that message has not been transmitted to individual clinicians who are being asked to supervise and that it is not evident in the hospitals' unwillingness to support supervision through reduced caseloads or other forms of encouragement.

The universities may be able to encourage more clinicians to supervise and support those already supervising by providing education in the area of supervision. First time supervisors often have expressed to me concerns about whether they are adequately prepared for their new role, and more experienced supervisors express a need for support in this role. In a practicum site survey conducted by the Faculty of Applied Health Sciences at the University of Western Ontario (Godden, Corcoran, Bossers, Ling & Morgan, 1990), respondents indicated a need for training to prepare them for supervision. In fact, obtaining education in this area was the most frequent response to questions concerning how clinicians might be encouraged to participate more extensively in student supervision and how the university might provide support. This seems to be a very immediate action that all universities could take. However, several of the Canadian programmes already provide some training in supervision to students and practitioners, and yet the clinical coordinators continue to express concern about recruiting and retaining supervisors.

Conclusion

The problem of finding student practicum placements is a long-standing one, and the issues raised here are obviously difficult to resolve. The question is — whose problem is this? If it is the profession's, perhaps it should be addressed by the provincial and national associations which could take the position that student supervision is a professional responsibility. If it is the university's problem then perhaps the seven Canadian programmes should develop and expand on-site clinics in order to assume responsibility for all clinical education. At the very least, the university should provide education on the supervisory process. If it is a problem for the government, which must deal with the limited services available to the community (and the insufficient numbers of professionals to staff more services), then perhaps the government should pay stipends to clinical educators and/or fund more staff positions so that facilities can provide time for supervision. If it is the problem of the clinics and school boards, which are short staffed and have difficulty filling positions even when they are funded, then these facilities too need to support clinical education. It seems that this problem affects all of us and that all must be involved in finding a solution. The future of the profession depends on it.

I remain convinced that student supervision is as much a professional responsibility, and as important a one, as provision of direct service. It is obvious that effective clinical education is dependent upon the opportunity to observe and participate in quality client care; it also seems that the quality of service delivery can be enhanced by a facility's involvement in student education. In the long run, quality of patient care will be compromised if well prepared professionals are not available.

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