The Collaborative Approach to Clinical Education

Recent changes in health care service delivery involve a shift from a medical-centred or clinician-centred approach to a client-/patient-centred approach. The days when the clinician was the ‘expert’ who told the client what to do are becoming a thing of the past. People with communication disorders and their families increasingly expect to work as partners with their health care professionals. This shift in the style of relationship between health care providers and their clients has implications for the education of speech-language pathologists. Student speech-language pathologists still need to learn how ‘to do speech therapy’. They also need to learn how to collaborate with families, other speech-language pathologists, and other health care professionals. For this reason, parallel changes have occurred in the area of clinical supervision, i.e. in the supervisor-student relationship. This has evolved from a teacher-student dynamic to one in which the *collaborative* aspect has become more central.

The collaborative partnership between Clinical Educator (CE) and student prepares students to become autonomous professionals as they get involved early on in clinical reasoning and problem solving. The student assumes greater responsibility for their own learning and is increasingly encouraged to engage in all aspects of clinical management and other clinical tasks, the end goal being autonomy through self-analysis and self-supervision. For the CE this approach may result in higher satisfaction levels, as she/he witnesses the outcomes of the efforts involved in this collaborative partnership. In addition, especially when working with a stronger student, they may experience the relation as collegial.

In a clinical practicum where a collaborative approach to learning is adopted students are expected to assume a more active role in their learning by taking more responsibility during the clinical learning process. This is likely also why the 2:1 peer coaching model (a CE provides a practicum to 2 students simultaneously) has proved a very suited cooperative learning model, as students depend on each other to instil joint clinical growth during the learning process.

This shift also has an impact on the role of the clinical supervisor: the supervising role now also subsumes that of collaborator and facilitator. Because the term ‘supervisor’ conjures the traditional roles of teacher and student, the terms ‘clinical educator’ (CE) and ‘clinical education’ would more appropriately reflect the new dynamics. Nevertheless, this does not mean that ‘supervising’ is not part of the clinical educator’s task, neither that using this term necessarily entails an unequal relationship, and the terms ‘supervisor’, ‘supervision’ continue to be used.

The Clinical Education Continuum (CEC)

STAGE I: **NOVICE STAGE**	**STAGE II:** **ADVANCED STAGE**	**STAGE III:** **MENTORSHIP STAGE**
STYLE/ROLE: CE:Active/direct teaching Student: Passive learner	**STYLE/ROLE:** CE: Collaborative → facilitative, coaching Student: Collaborative → active, self-directed learning	**STYLE/ROLE:** CE: Consultative/ Mentoring Student: Consultative/ Self-supervision

Time →→→→→→→→→→→→→→→→→→→→→→→→→→→→→→→→→→→ Time

[This is a free adaptation of Anderson’s “Continuum of Supervision” model (1988)]

A collaborative model of clinical education

The premise of a *collaborative* approach between the Clinical Educator (CE) and the student in a clinical practicum is that the learning process takes place on a continuum consisting of three main stages, each with its distinct characteristics, as will be seen later on. As the student gains competence, experience and confidence over the course of their clinical education (within a single practicum and throughout a series of clinical practica, culminating in the final internship) their learning needs and learning *styles* will change. Initially they will be dependent on the CE for receiving a lot of information and guidance for a wide variety of clinical tasks. Increasingly, as the new information becomes integrated with theoretical knowledge and experience, students will start to take increasing responsibility for clinical tasks. They will start to conduct with gradual independence test analysis, figure out the nature and degree of the presenting problem, engage in mutual problem-solving and case discussion with their CE or a peer. They will also rely more and more on self-supervision skills, and eventually will take responsibility for their own caseload. The CE's role changes therefore as well - and ideally this role change starts quite early on - from traditional instructor or supervisor to facilitator and collaborator. As students become more experienced they will always encounter novel situations (new populations, more complex cases) during which they may move back temporarily to the stage of 'passive learner', while the CE's primary role may for the time being return to being that of 'instructor'.
Basically, the student *and* the CE evolve over three broad stages of the learning continuum during which their roles or styles will change, and this may happen either within the same practicum or over a series of practicum experiences.

<u>The three stages</u>
Stage I: The "Novice Stage" is short and resembles the traditional supervisor-student relationship with the supervisor (CE) doing the teaching and the student being a more passive learner, with little need to take initiative or responsibility for their own learning.
Stage II: The "Advanced Stage" is the longest and during this time the student will become increasingly independent in the various clinical skills to be acquired. The nature of the relationship between CE and student will become collaborative.
Stage III: The "Mentorship Stage" is short forms the last phase of the clinical education continuum. During this stage students hone their skills and will rely less and less on their CE who will become an advisor or mentor.
Where students find themselves on the continuum is determined by various factors, the most obvious being: level of knowledge, clinical experience, competency and confidence and more often than not they may be at different Stages of the spectrum for different skills/tasks (see "cyclical nature" below)

<u>Styles (roles) corresponding to each stage</u>
The *styles* or *roles* of both parties change according to the Stage on the continuum where the student finds her/himself - not only within a single clinical practicum but across the entire clinical learning spectrum (from the first practicum to the final internship). When the role of one party changes so will the other's. For example, the role of the traditional supervisor as 'expert' automatically places the student in the subordinate role of 'passive learner'. This may be the situation for a student's first practicum, but the ideal is that the student moves fast to the early phase of the "Advanced Stage" so that a collaborative approach can be quickly applied. When a clinical practicum becomes more collaborative then *both* parties' roles will (need to) change: the CE's role will change into that of a 'coach' by encouraging the student to take more initiative, or they will problem-solve together rather than the CE giving the answers, and thus the student will become actively involved in the learning process. The end goal, i.e. the "Mentorship Stage", is for the student to become an autonomous learner. By this time CE-student relationship has become consultative: the student relies more on self-supervision and seeks guidance from the CE as required and the CE assumes a mentorship role.

The cyclical nature of the clinical education process

At the start of a new practicum it is important for CE and student to determine where the student is on the learning continuum, and that the evolution is going to be monitored throughout the practicum. During initial discussion between CE and student it may transpire that for certain tasks or skills the student is at a beginning level, whereas for other tasks/skills the student is already at a more advanced level.

For example, the focus of a student's first practicum was on intervention; by the end of that practicum the student has reached the earlier phase of Stage II, the "Advanced Stage". In the current practicum the student is introduced to assessment. This does not mean that the student is back at the "Novice Stage". Having already worked with children, the student has already acquired many important skills to work with that population. While becoming familiarised with assessment the student will momentarily move back to the "Novice Stage", but this should be for a very short time. Similarly, if a student learned to administer pediatric assessments during a first practicum, and then does a second practicum with adults, learning to use adult assessment tools may necessitate only a temporary moving back to the "Novice Stage".

Clinical Educator and Student, Is the Collaborative Approach for you?

Several basic elements are important to consider before adopting the collaborative approach. Perhaps the most important is for CE and student to be on the same wavelength. If the student's perception of her/his role is that it is subordinate and the CE advocates a more collaborative approach; or the reverse, if a student perceives her/himself as competent and confident, and prefers a collaborative approach but the CE is used to the traditional way then this may lead to a clash.

It is important that each party be aware of each other's comfort level with a certain style, and to discuss any discrepancies. For example, a CE may expect a student to be at a collaborative stage. However, from the student's point of view, factors such as limited theoretical knowledge or experience, anxiety, lack of a sense of what this 'collaboration' is all about may stop a student from moving on. In this case either a more 'direct' approach may be preferable or the CE's priority may lie with helping the student to ease into a collaborative approach more slowly.

Another example: a student may see her/himself as more independent because they received a high evaluation in a previous practicum. Discussion may reveal that the student overestimates her/himself and that it might be wise to take a step back, briefly, or that perhaps the student is indeed ready to work at a higher level, in a different role.

It is always advisable that both parties be aware of these issues and discuss on an ongoing basis at what stage the student is perceived to be and what roles are going to be assumed by both parties.

Potential danger may also lie in CEs giving too much responsibility to students too early, for whatever reason: being too busy, preferring student carries own caseload, having worked with a more experienced or an exceptional student in a previous practicum. The CE may treat the student as a Stage III student and offer minimal supervision, when the student is not ready for this. This would not reflect the 'collaborative' approach as the underlying notion of the approach is that open communication between the two parties would give the student an opportunity to indicate at what stage she/he perceives her/himself to be.

Another fact to be aware of is the CE's approach and philosophy toward clinical education/supervision. Some CEs may not be comfortable with a collaborative approach and may prefer to supervise in the more traditional supervisor-teacher/student dynamic throughout the clinical education process. Similarly, some students may feel threatened at the idea of having to take on responsibility, for whatever reason, and may expect a more direct role from their CE while they assume a passive role during practicum, or they may not feel comfortable with self-evaluation.

One's personal characteristics will likely always play a part in roles being assumed; for example some students will naturally have a tendency to be more passive or active learners. Similarly CEs will also have a natural tendency toward either leaning more toward a directive or a collaborative approach.
Whatever approach is taken in the end, clarification of each party's position on this issue requires discussion as it will impact in great ways on how the supervision of a student will take place during practicum and may help avoid potential conflict. Therefore, it is strongly recommended that this be discussed when the Practicum Contract is completed by the two parties at the beginning of a practicum.

Clinical Education Stages & Styles (Roles) - some examples

Stage I: "The Novice Stage"

During Stage I the CE's style is *active* and *direct* and the student's role is more *passive*. The novice student will be expected to follow CE's directives (more like the traditional teacher-student dyad). This stage should be short. Although the student is not expected to engage in a great deal of problem-solving or analysis this should be encouraged early on to help the student move quickly to Stage II.

Student Tasks	CE Style
Observing CE	Modelling
Taking directions, asking questions	Giving directions, explaining, teaching
Joint assessment/therapy	Joint assessment/therapy
Note taking/report writing, with a large amount of CE assistance	CE may provide samples of reports, templates
Receiving feedback; however, self-evaluation is encouraged from the beginning	Giving feedback; teaching student to self-evaluate

Examples:
- At the beginning of the first practicum (e.g. McGill "May Practicum") students may do observations in the first few days, and become gradually more involved by doing 1 or 2 therapy activities and/or in joint sessions with the CE, and then gradually do take over with CE giving guidance as needed. (At this point student should move to Stage II.)
- When a student in their 2nd practicum deals with a new population or more challenging client(s) more hands-on guidance from the CE may be required, but for as short a time as possible and for very specific tasks only.
- Weaker students: e.g., demonstrating poor theoretical knowledge; difficulty applying theory to practice; demonstrating poor interactional skills; weak problem-solving skills; overwhelmed by dynamics of the situation; etc.

Stage II: "The Transitional Stage"

This stage is the longest and will show the greatest evolvement on the part of the student. The student is expected to take increasing responsibility for their learning, which is reflected by the style of supervision becoming increasingly *collaborative* and *shared*. The assumption is that the student has reached a certain level of competency and confidence at this stage. The focus of the supervision process is increasingly on *joint* participation, problem-solving and decision-making during the clinical process (e.g. CE and student together set the objectives for client *and* student) and the student is expected increasingly to be able to give feedback on both the client's and their own performance. Self-evaluation is strongly recommended.

Student tasks versus CE style

1. During the earlier phase of Stage II, the student engages increasingly in solo assessment/therapy. The CE may initially sit in on the session and step in as required. Increasingly, the student will be able to make their own modifications during sessions and/or do

this during debriefing sessions with CE. Student will also demonstrate increasing ability at problem-solving. At the end of a session CE & student discuss client and student performance, while student learns increasingly (also through CE guidance) to analyse client and own clinical behaviour; student also learns to plan future strategies for client and self. For charting and report writing the CE will initially provide more direct guidance.

Examples:
- A more advanced student in the second half of a May Practicum.
- The student has already undertaken a first practicum and is starting the fall, winter practicum or internship, especially if she/he has already worked with a similar population.

2. During the later phase of Stage II, the CE may take a lower profile, and the CE's role will become increasingly facilitative. The CE and student may debrief sessions at a predetermined time, and discuss client and student performance, while increasingly the student is expected to take the lead. Over time the student is also expected to learn to identify the specific needs for these discussion sessions. The student may also start to adopt responsibility for higher level tasks with decreasing involvement from CE. (e.g. counselling, consulting parents, spouses, third parties, etc.)

Examples:
- Towards the end of a fall or winter practicum.
- In the later stages of an Internship.
- Exceptionally, a very strong student in a May Practicum.

Stage III : "Self-supervision"

At the Self-Supervision Stage the student is working toward or has reached virtual *autonomy*. The role of the CE has become more that of a *mentor*, i.e. the relationship has become *consultative*. At this stage the student:
- can problem-solve cases independently: as a rule the CE no longer needs to observe, help analyse results or provide feedback (possible exceptions being: more atypical or challenging cases; if the setting's policy prohibits students from working independently with clients; for the purpose of the formal student evaluation)
- has the ability to accurately analyse her/his own clinical behaviour and its outcomes and to alter it based on that analysis
- is responsible for her/his own professional growth
- needs access to CE for discussion in the role of a mentor (this aspect is invaluable!)

Examples:
- During the final stages of an Internship.
- Earlier on during an Internship in the case of a more straightforward caseload.
- Earlier on during an Internship in the case of a student who had already obtained prior experience and competency with a particular population/communication disorder.
- Earlier on during an Internship in the case of an exceptionally strong student.
- Following graduation, when the student as a new grad enters a period of mentorship (which may be a requirement of a professional college or association).

Fluctuation between stages

As mentioned above, the nature of the clinical education continuum tends to be cyclical: often students during a particular practicum will be at different stages for different clinical tasks, which will impact on the degree and type of supervision/guidance required from their CE for these various tasks. This may also apply to a situation where a student may already have attained competencies with a certain population/communication disorder in a previous practicum but may temporarily need to move back a stage when adjusting to a different population in a new practicum.

Examples:

- A student has already administered the PLS-4 during a previous practicum with preschoolers and is introduced to the CELF-4 in the current school practicum setting. This means the student returns for hopefully only a brief time to Stage I while becoming proficient at administering the new test. When interpreting the CELF-4 results with the CE this may happen at a Stage II level based on the student's previous experience with test interpretation.
- A student commences their second practicum, which constitutes their first experience with adults. Although for many aspects the student will start at Stage I level, transition to Stage II may be relatively fast as prior experience with pediatric population should generalise to the adult population.
- A student may be at Stage II in many domains but has poor self-evaluation skills; for the latter he/she would remain at Stage I.
- During an earlier practicum in the case of strong student and/or a relatively straightforward caseload: Stage II vs. Stage III:
  For example, administering and interpreting the same test or screening tool multiple times. Before a student is moved to Stage III, the student would need to give evidence that she/he has indeed attained the necessary competencies in the clinical skills involved in this task. This student may be at Stage III for administering tests but at Stage II as she/he continues to require more direct guidance from the CE with interpreting and/or discussing the results of more challenging cases.

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