Issues and innovations in clinical education

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Abstract
The provision of adequate, high quality clinical education for speech pathology students is becoming increasingly challenging, due to a range of changes and attitudes within all groups who have an interest in clinical education. Significant changes in speech pathology workplaces and employment patterns of speech pathologists, and concurrent changes in universities have created a situation of minor to extreme shortage of clinical placements in many countries. The appropriately high standards but sometimes prescriptive expectations of professional associations, accrediting bodies, and licensing or registration boards in some countries exacerbates the problems faced in developing alternative placement opportunities and supervision models. At both systemic and individual levels, some clinical educators hold on to beliefs and clinical education practices which are outmoded and impede the development of alternatives to the provision of clinical education. This article explores some of these issues, discusses some innovations in clinical education and challenges stakeholders to critique their positions and practices concerning clinical education.

Keywords: Clinical education, supervision, fieldwork.

Introduction
In this paper I address a number of common concerns and issues regarding clinical education of speech pathology students, with which universities, workplaces, clinical educators and students in the Western world are grappling at the present time. I will discuss some of the factors that contribute to these issues and then describe some innovations that have been developed to meet the challenges faced in clinical education. Although this article is focused primarily on speech pathology clinical education in the English speaking countries, many of the issues and innovations presented here also apply in developing countries. I have drawn where possible from the literature, but also include descriptions of issues and innovations drawn from my experiences of studying, working and attending meetings and conferences in Australia, Canada, Malaysia, New Zealand, Singapore, the United States of America (USA), the United Kingdom (UK) and Vietnam. I have also drawn on my 30 years as a clinical educator (mainly in Australia but also in Vietnam), and my 15 years as a clinical coordinator/director of clinical education programs. Colleagues from around the world who will respond to this article will no doubt challenge some of my Australian-centric and Western-oriented assumptions and interpretations, and provide further insights into and suggestions for managing the complex problems associated with the provision of clinical education in their countries. I acknowledge that in writing as an Australian, I am using the terminology of my profession in this country: speech pathology (also known as speech therapy, speech and language therapy, speech-language pathology in other English speaking countries), and clinical education (referred to in other countries and professions as clinical supervision, fieldwork education and fieldwork supervision). Both terms “patients” and “clients” are used; however, as I practise within a non-medical model, I have more often used the term “client”.

Current issues in clinical education
In the first part of this paper I will outline several issues and the impact they have on the provision of clinical education.

- Changes in the workplaces of speech pathologists;
- Changes in education of speech pathologists;
Changes in the workplaces of speech pathologists

Increased pressure in workplaces

Speech pathologists are experiencing increasing pressures in their workplaces, including the need to see more clients, deal with more patients with complex needs, respond to ever increasing numbers of workplace policies and legislative requirements, broaden their roles to include more client, family, carer and community education and health promotion, search for, interpret and apply the results of research to provide evidence-based practice (Reilly, Douglas, & Oates, 2004), provide assessment and treatment in shorter time frames due to decreased length of stay for patients in hospitals and rehabilitation facilities, and document their accountability and productivity. Such pressures are often coupled with inadequate staffing levels, chronic staff shortages, and problems with recruitment and retention of staff (American Speech-Language-Hearing Association (ASHA), 2003; Iacono, Johnson, Humphreys, & McAllister, in progress; Rossiter, 2000; SARRAH, 2002). Economic rationalism has meant that many publicly-funded human services workplaces (e.g., hospitals, rehabilitation facilities, community health centres, university clinics) operate on a business model where cost-effectiveness and if possible cost recovery are key drivers.

In environments such as these, there are two main impacts on clinical education of students. Firstly, clinical educators tell university staff that they do not have time to take students, that they can not fit them into already overfull and pressured days. Secondly, even where clinical educators are willing to take students, managers sometimes direct staff not to do so, as student education is not “core business”. Even major “teaching hospitals” increasingly find they do not have the time to teach students. Some workplaces also tell us that students are a drain on their resources, take time away from clients and lead to decreased productivity. However, there is no evidence to support this negative view of the impact of students on facilities and clients. Requests from facilities for payment for clinical placements cannot be supported given research which suggests that productivity in terms of both direct and indirect client care increase when students are on placements (Bristow & Hagler, 1997; Ladyshewsky & Barrie, 1996; Ladyshewsky, Barrie, & Drake, 1998; Patterson, 1997).

What are the longer term implications of these pressures on provision of clinical education? One obvious outcome of reduced numbers of clinical placements is that university staff must spend more time trying to find or develop clinical placements for students. For example, a few years ago the clinical coordinator and the clinical placements administration officer at the university where I work, between them spent 300 hours calling clinics across four states trying to find 30 placements for students in adult neurological settings. Another implication is that universities must collaborate in the management of clinical placements. For example, to maximize access to any placement offers and to reduce pressure on clinics and clinicians arising from multiple requests from the four speech pathology degree programs in New South Wales, Australia, a clinical education consortium collaboratively seeks and allocates clinical placements, and provides professional development for clinical educators. Universities are also actively seeking to develop more traditional clinical placement opportunities by working with government departments, health facilities, and non-government organizations to establish dedicated student teaching units, where the primary responsibility of the appointed clinical educator is to take students, often full time year round.

Universities are also developing non-traditional placements, where students may be in sites that do not yet have speech pathologists on staff, to assess the need for and design ways to develop a speech pathology service, or to work consultatively alongside other professional staff to provide communication enrichment of existing programs for clients. Supervision may be provided using a mix of on-site and off-site supervision from speech pathologists and other professionals (see below for further discussion of such innovations). Even with such collaboration and innovation, insufficient placements in some caseload types (e.g., adult in-patient and rehabilitation) continue to exist, and in some cases course completion for some students is delayed until such placements can be found.

As well as the impact on universities and students, there are also significant impacts on clinicians and workplaces. In Australia, both the Code of Ethics (Speech Pathology Australia, 2000) and the Competency-Based Occupational Standards (C-BOS) for Speech Pathologists – Entry Level which describe competencies for beginning level practice (Speech Pathology Australia, 2001) state that speech pathologists should be involved in the provision of clinical education of students. Many clinicians are anxious about the inability of their workload or workplace to accommodate student placements. They regret that they do not have the opportunity to “give something back” to their profession and the university which educated them. We know from research with clinical educators (Brammer, 1996; Edwards, 1996; McAllister, 2001) that many clinicians enjoy having students; they add fun and humour to workplaces, create opportunities for personal and professional
growth (McAllister & Lincoln, 2004), offer new ideas and resources, and help keep clinicians “on their toes” (McAllister, 2001). Staff motivation to remain up-to-date has been found to be lower in sites that do not take students (Ballinger & Diesen, 1994). In addition, sites which do not take students have more difficulty recruiting new graduates than sites which do (Ballinger & Diesen, 1994; Thompson & Proctor, 1990). Major employer groups such as state health departments report that induction of new graduates can take longer if graduates have not had clinical placements in their sector, work satisfaction can be lower and turn-over higher. These research findings all suggest that investment of time and resources into student education produces net gains rather than net losses for workplaces.

Changes in the models of speech pathology practice

The last few decades have seen major philosophical changes in constructs of illness and health and re-direction of health care funding away from tertiary hospitals into communities (McMurray, 2003). Concurrent with these changes, the medical model under which speech pathology as a profession developed has been challenged by newer models of practice including the social model of disability (Duchan, 2001) and community-based rehabilitation. The significant changes in professional practice consequent to these paradigmatic shifts are reflected in the various documents of professional associations and accrediting bodies which set the standards for practice as a speech pathologist. For example, the final three of the seven units of competence in the C-BOS for Australian speech pathologists (Speech Pathology Australia, 2001) are concerned with Planning, Maintaining and Delivering Services, Professional, Group and Community Education, and Professional Development. The work of Williamson (2001, 2002) on behalf of the Royal College of Speech and Language Therapists (RCSLT), and the American Speech-Language-Hearing Association (ASHA) (1996) have similarly identified a broad range of competencies required for contemporary practice in the UK and USA respectively. University programs have attempted to respond to these changes by adapting the content of both the academic and clinical education programs, as discussed later.

Higher expectations for new graduates

Despite the fact that most professional associations advocate limits on the scope of practice and independence required of new graduates (see as examples the Range Indicator Statement in C-BOS, Speech Pathology Australia (2001, p. 3); Clinical Fellowship Year Requirements, ASHA, 2005), the reality is employers want their new graduate employees to be “oven ready” (Brumfit, 2004). In countries with widely dispersed rural populations like Australia or numerous small population centres (as in the UK, Canada and the USA), and in countries with recruitment and retention problems, many new graduates end up in sole positions where their nominated supervising or senior speech pathologist may be one or more hours’ drive away, or a one or two hour plane flight away as can be the case in remote areas of Australia. Survival in such positions requires a sound level of management skills. Further, even in larger urban departments with several speech pathologists, the work of Adamson, Lincoln and Cant (2000) on the expectations of new graduates held by health service managers tells us that employers want graduates to fulfil a range of management tasks. The level of management skill and responsibility inherent in some of these tasks is considerable. These are listed in Table I.

Increased specialization

Speech pathologists work with increasingly complex client groups and their families and carers, due to life-saving and life-prolonging innovations in medical technologies, the need to work within multi-cultural societies and so on, as described by Pickering and McAllister (1997). Depending on their work setting, speech pathologists may well be working with acutely ill clients or clients with chronic conditions which require specialist knowledge. Research and higher education opportunities, together with the expansion of speech pathology staffing in major sites (e.g., large urban hospitals) means that more speech pathologists are now specialists in particular areas such as head and neck cancer, intensive care, head injury and voice.

The development of specialization is important for the profession and clients, but it makes the provision of student placements a challenge. Some specialist speech pathologists feel they cannot offer placements either because of the sensitive or fragile nature of their clients, the confidentiality issues involved, or because they feel they cannot provide a placement diverse enough to enable students to meet a range of learning objectives. These specialist speech pathologists work in the very areas in which it is hardest to get clinical experience for students. Clearly universities and clinicians need to work collaboratively to create differently structured placements. Students

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<th>Table I. Management skills expected of new graduates by health service managers.</th>
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<td>1. Department running</td>
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could for example spend one day per week with a specialist clinician and the remaining time with other clinicians on site or in other sites. The current utilization of block placements (e.g., four or five days per week for some weeks) rather than one day per week placements across a term/semester or year, may need to become more flexible.

**Generic roles of speech pathologists**

Work settings for speech pathologists have broadened in recent years to encompass more than a traditional clinical role, one to one with clients. All health professions are increasingly working as a part of interdisciplinary teams (Johnson, Wistow, Schulz, & Hardy, 2003; Williams, Remington, & Foulk, 2002) and in collaboration and consultative models of practice in education and disability. Skills for working in teams, implementing team goals for clients, and functioning as team leader, case manager and consultant are essential additional professional skills in such contexts. Speech pathologists need not only their discipline-specific knowledge and skills, but strong generic attributes such as interpersonal communication and conflict resolution skills, and a willingness to share knowledge and skills with other professionals and appropriately teach other professions and clients and their families. In response to the World Health Organization’s (1986) promulgation of its Ottawa Charter, speech pathologists like most health professionals have increasingly added health promotion and community education to their work roles (Wass, 2000). In some sectors (e.g., working with socioeconomically disadvantaged groups including migrant and indigenous communities) speech pathologists work within a community-based rehabilitation (CBR) model. Speech pathologists are also taking on case management roles for clients with needs broader than communication and swallowing. For example, speech pathologists may approve and coordinate rehabilitation services for insurance companies. This genericization of health professional work may mean that speech pathologists spend less time with clients directly and more time with teachers, parents, carers, co-workers or residents in supported living and working environments, and other human services professionals.

These changes in work practice are an exciting and inevitable response to worldwide trends in health care delivery. However, in terms of clinical education, these changes mean that many speech pathologists feel they can no longer offer placements that fit with what they believe universities want and students need. Speech pathologists in team or generic settings tell clinical coordinators they can’t provide students with “a normal placement” (i.e., one-to-one with a client) or “clients of their own”. Such placements are often seen as harder than the one client to one student model of “doing therapy”. Yet these are the very types of placements that would allow students to develop the broad ranging competence needed for entry to the profession (e.g., Units 5, 6 and 7 of C-BOS, Speech Pathology Australia, 2001; Williamson, 2001, 2002). These are also the types of placements needed to prepare practitioners to address population health issues, and respond to the challenge of redirection of health dollars and patients from hospitals to community settings.

Given that diverse work settings, models of practice and roles outlined above are both a permanent and desirable feature of contemporary practice settings, how can universities, workplaces and clinical educators work together to provide more clinical placements? It is clear that university programs need to prepare students for placements and subsequently employment in such settings. They also need to assist clinical educators to identify ways in which they can offer and support placements for students in such settings. Learning goals for placements may need to be adapted by university programs, so that teams skills, generic skills, case management experience, health promotion and so on become the foci of some placements. The traditional clinical skills and attributes of speech pathologists may be targeted concurrently or separately to more generic placements. McAllister, Wilson, Clark, McLeod, Beecham and Shanahan (2004) have reported on one program which prioritizes educating speech pathology students in non-traditional placements, where the learning goals and activities are directed towards improving equity in service delivery, resourcing rural health service delivery, participating in community needs assessments, developing and delivering health promotion programs, and engaging in capacity building and agent training.

There is significant debate amongst university educators about the sequencing of the teaching of theory versus clinical practice, and also on timing and sequencing of traditional speech pathology clinical experiences versus non-traditional or generic placements (see Baxter, 2004, for a discussion of some of the assumptions involved in these debates). Some educators suggest that theory should come first followed by clinical, leaving much of the clinical placement until later in the program. Others intertwine theory and practice throughout the program. Still others embed their theory teaching in clinical practice contexts. Of course the majority of programs use some combination of all this. Some educators argue that traditional experiences with clients one on one or in small groups, perhaps in controlled settings like university clinics, should come first. Other educators (e.g., Beecham & Clark, 2004) argue that given the trends in health care and the need for more services for disadvantaged populations, early clinical placements should target community and educational settings, collaborative interprofessional team work and consultation, to establish these as core
roles in professional practice, not “add on” roles. In response to such arguments, Charles Sturt University’s speech pathology program has just introduced as students’ first clinical practicum, placement of beginning students with senior student mentors in classrooms to work with teachers on functional, whole-of-classroom language needs assessment, and whole-of-class teaching around collaboratively established communication goals. Students receive intensive on-campus pre-placement briefing, continued on-campus based tutorial support targeting issues that come up regarding client/classroom assessment and programming encountered whilst on placement, and post-placement debriefing and assignments drawing on the practicum experience. Given that the students will be working alongside teachers in the classrooms, teachers will take a primary supervision and assessment role with the speech pathology students. The senior students are also concurrently receiving input and support to take on “supervision” roles with their less experienced student peers. Staff will be evaluating the students’ experience closely (as well as teachers’ experiences and pupils’ outcomes) to investigate whether attitudes to “what is normal practice” shift relative to other student cohorts who have not had this experience. Clinical educators need to not only innovate, but also to evaluate and disseminate those innovations.

An increasingly part-time speech pathology workforce

In line with labour force trends around the world resulting in casualization of the workforce, coupled with lifestyle choices for working fewer hours or having more flexibly, (perhaps but not always to accommodate family needs), many speech pathologists are opting to work part-time. Part-time work is also common in smaller rural population centres and in new services where the target client population is not yet sufficient to appoint a full time person. In Australia, it is estimated that about 49% of the speech pathology workforce now work part-time (Lambier, 2002). Other developed countries would probably have similar experiences.

There are numerous personal and professional benefits of part-time employment, including the retention of experienced speech pathologists in the workforce. However, in an attempt to maximize student learning and professional socialization, a concurrent counter trend has been for universities to move more student placements into blocks (4 – 5 days per week for 3 – 10 weeks) rather than use half or one day per week placements. While this may make educational sense, it is becoming more logistically challenging; a clinical educator may be willing to take students but not available full time. There is clearly a need for universities and workplaces to work together to provide more flexible placements (e.g., 3 days a week for 10 weeks rather than full time for 6 weeks), or to create full-time placements across sites with two clinical educators sharing a placement and students. Shared supervision across sites and/or across clinical educators can be both rewarding and problematic for students and their clinical educators. The rural placement initiative of The University of Sydney (1998) offered principles, strategies and case examples of how to make such innovations work. Although the examples are rural, the recommendations apply also in urban areas.

Growth of private practice

There has been significant growth in private practice in our profession in recent years. For example, Speech Pathology Australia’s labour force study (Lambier, 2002) suggests that at least 40% of speech pathologists who are members of the association (estimated to be 60 – 70% of the number of speech pathologists practising full or part-time in Australia) report they are engaged in some level of private practice. This may be anything from full-time private practice to one or two clients per week, as a sole setting of employment or concurrent with public sector employment. The rapid growth in private practice is attributable to a number of factors including: a desire in speech pathologists for increased autonomy and flexibility in working hours and conditions; decreased service provision in the public sector and consequent demand from patients who are not eligible or have received their entitlement of services in the public sector; growing reimbursement options for private services; and a better educated public who are aware of the range of service delivery options and treatment approaches available to people with communication and swallowing impairments.

The growth of private practice has improved client choice, contributed to the growth of the profession and retained experienced clinicians in the workforce. However, it has not provided more access to clinical placements for students. While clinical education of students in private practices is the norm in several professions (e.g., general practice, physiotherapy, podiatry), this is not the case in speech pathology. Universities need to work more closely with private practitioners to find ways to satisfy the aspirations of students, patients, universities and private practitioners. Armstrong, Fordham, and Ireland (2004) describe one successful model for increasing the provision of student placements in private practice. The paper addressed common barriers to private practitioners taking students, including respecting client preferences to see the clinician of their choice, obtaining informed consent from clients for the student to work with them, meeting health insurer requirements about who treats and bills, and not disrupting the income stream for the speech pathologist.

This section has touched on some key workplace trends which impact on the provision of student
clinical education. Concurrent with these changes in workplaces have been significant changes in the education of students for entry into the speech pathology profession. The changes in both sectors are linked, with each sector driving and responding to changes in the other sector.

Changes in education of speech pathologists

In 1997, Pickering and McAllister described several changes impacting on higher education around the world that would inevitably also affect clinical education in the health professions. We discussed not only the significant increase in numbers of students seeking higher education but also the increasing diversity of student cohorts in terms of cultural and linguistic backgrounds, age, prior work experience and increasing numbers of students with disabilities seeking to enter the health professions. We noted the increasing diversity of structures, programs and modes of study as they affect all professions, especially the health professions. The growing financial and resource constraints beginning to be experienced by many universities were also highlighted. In the last decade, these trends have continued.

Diversity in student cohorts

In my experience, we now have many more mature age students from diverse educational and work backgrounds studying speech pathology. These students often must juggle study, work and family demands, and in order to do this, are demanding more flexible and efficient modes of study and clinical education. In addition, programs are being asked to recognize prior professional learning and work experience in human service professions such as nursing, psychology and teaching. The growth in 2–2.5 year Masters entry courses is in part driven by the need to accommodate such students. We are also seeing more cultural diversity in our student cohorts. Students from the newer migrant groups such as Vietnam, and a range of Islamic countries are entering our programs. This diversification of student cohorts is a worldwide trend. It will in the long-term lead to enrichment of the profession and provide more culturally appropriate service to our clients. However, in the short term it provides challenges for clinical educators to be even more flexible and culturally sensitive and competent in working with such diverse student populations.

Growth in number of speech pathology programs and students

The numbers of students entering speech pathology programs, and the number of actual programs continues to grow around the world. Since 1998, seven new speech pathology programs have commenced in Australia, with five more in development. Growth in programs is also occurring in the UK, Ireland and South East Asia. In contrast there has been closure of some speech pathology programs in North America. The consequent growth in numbers of graduates may help meet the significant demand for our services in the community. However, there is considerable concern that employment in the public sector may not grow at a rate sufficient to provide jobs for all these graduates. So far, this has not been the case in the UK and Australia, two countries with rapid growth in graduate numbers. There continues to be significant problems filling positions in Australia, South Africa, the UK, the USA and other countries. The more pressing concern from the clinical education perspective is how to provide placements for all these students. Student numbers have expanded at the same time that participation of workplaces in clinical education has contracted, as discussed above. There is an expectation from some workplaces that universities must fund the growth in clinical placements. However, universities are experiencing significant contraction in real funding and staffing levels. In many countries, university staff-to-student ratios have decreased to levels that staff believe to be unsustainable if quality is to be maintained. There is no spare financial or staffing capacity to provide clinical placements in the way these have been conceived of in the past. Providing more of the “traditional” type of clinical placements is proving to be extraordinarily difficult to achieve. Therefore, new models of clinical education and innovative types of placements must be developed, whilst also ensuring a high quality clinical education for all students. Some of these have already been presented in this article.

Educational responses to changes in the nature and scope of professional practice

With changes in work setting and the nature of practice outlined earlier, universities have responded by broadening the goals of clinical education, expanding academic offerings and providing more opportunities in their clinical education programs for students to obtain experience in non-traditional settings. Students in many programs now work in a range of models of service delivery which move well beyond the traditional, medical model of one to one treatment sessions with clients. Speech pathology students may be placed in services that do not yet employ speech pathologists, with clients with special needs. They may undertake needs assessments, plan, deliver and evaluate health promotion programs, or consult and collaborate in the classroom with teachers to deliver speech and language programs to children with special needs. Supervision may be provided by speech pathologists (who may or may not be on site) or by other professional groups such as teachers or by some combination of the two, using
direct and indirect modes of supervision. The innovations by McAllister et al. (2004) described earlier and Baxter (2004) both use new approaches to supervision.

Baxter (2004) reported on innovative approaches to clinical education and the provision of speech pathology services in schools and nurseries in the UK. Students worked with peers and nursery or school staff to develop appropriate programs for children with communication needs. They were prepared for their placements by university tutors, and received support during the placement from the staff at the sites and from intermittent visits to the sites by university tutors, and from regular meetings with university tutors on-campus. Peer learning, shared supervision and distance supervision models were all successfully used. The evaluations of these innovations were positive, and areas of improving the model for the future were identified. Like so much about clinical education, we do not have research which guides clinical educators to make informed curriculum decisions. Evaluation of the short-term outcomes (student learning and client outcomes) and long-term student learning and client/teacher/family outcomes of such innovations are important.

While these innovations are important in preparing graduates for the realities of contemporary practice, they create inevitable tensions between development of speech pathology-specific knowledge and skills versus generic competencies, preparation for old roles (that of the “therapist”) as well as new roles (consultant, service developer, advocate), skills for work in medical settings versus other settings, and the need for close supervision to ensure client safety in some contexts versus the possibility of more self-directed practicum in others. New graduates must be prepared for work in all potential settings. How can universities respond to these diverse needs without dilution of learning outcomes? Undoubtedly, the focus of clinical education must broaden, but how can this be achieved without loss of quality, and compromised “safety” for both clients and students?

Many directors of clinical education programs argue that the pressures experienced due to the concurrent phenomena of growing student numbers, shrinking placement opportunities, employer demands, and the realities of contemporary practice are further exacerbated by the high standards set by accrediting bodies for curriculum content and the competence of graduates.

**Clinical education requirements of accrediting bodies, registration/licensing boards and professional associations**

All around the world, professional and/or government bodies set standards for the accreditation of speech pathology courses and recognition of new graduates. Curricula are reviewed against a set of criteria which specify topics which must be covered, to what depth, and in some cases minimum number of hours of topic coverage are prescribed. Often, some predetermined number of hours to be spent in types of clinical placement is also prescribed. For example, ASHA stipulates that students must achieve 350 hours of face-to-face experiences in assessment and treatment of both children and adults with speech and language impairments. Canada also mandates 350 hours of clinical practice. Speech Pathology Australia abolished the requirement for 300 hours in specific categories when it introduced its Competency-Based Occupational Standards (Speech Pathology Australia, 1994, revised 2001). University programs were freed to structure their academic and clinical curricula as they saw fit, provided they could demonstrate that all their graduates were assessed at the point of graduation as “competent” with a wide range of impairments and age groups, and the ability to work in a range of service delivery models with a range of stakeholders. This has led to a proliferation of highly innovative clinical education programs and experiences, some of which are reported in this article.

Are the standards for new graduates realistically achievable?

Like most countries, Australia has found it challenging to provide the range, quality and amount of clinical experiences needed to meet accreditation requirements. This is not only because of the shrinking opportunities for direct clinical experience, but also because some caseload types present rarely or only in specialist clinics not able to be accessed by a majority of students. In some cases, professional bodies have “loosened” up on the requirements a little. For example, although ASHA increased the required number of clinical hours from 300 to 350, they reduced the number of categories in which these clinical experiences were to be acquired to two – speech and language. University programs appear to have found it easier to meet the hours requirements with broader categories. Speech Pathology Australia accepts that it is difficult for students to obtain face-to-face clinical experience with both children and adults in the less frequently occurring clinical case loads such as voice, fluency and paediatric dysphagia. They will accept that competence can be developed and demonstrated in a range of ways, including direct clinical experience, problem-based and case-based learning, simulations, and micro-clinical skills development. University programs are becoming increasingly creative in the structure, content and delivery of both their academic and clinical curricula. Whitworth, Franklin and Dodd (2004) described the development and structure of a speech pathology program using a modified problem-based learning approach. This method is also in use in speech pathology programs in Australia and other countries. University programs are also making...
greater use of information technology to develop case-based instruction such as PATSy (Lum & Cox, 1998). University programs are also questioning their clinical education programs with regards to what, when, how much, with whom, and where should they provide clinical education.

**How much clinical education is needed? What types? When? Where?**

Prescribing a minimum number of hours of clinical experience in specific categories or a set of experiences which must be provided for students assumes that we know how much and what types of clinical experience is needed to achieve entry level clinical competence. We do not in fact know this. What we do know is that students vary enormously in what they bring to clinical education in terms of prior life and work experience, learning styles, personal attributes, self-directed learning skills, abilities to reflect on and learn from experience and generalize this more broadly. All clinical education program directors share stories of exceptional students who seem ready to graduate after only 100 hours of clinical experience, while others despair of students still not deemed competent or passable after 400–500 hours. We do not know what types of clinical education modes and experiences are most important in the achievement of competence. We assume a mix of pre-clinical preparation, direct client contact and other modes of learning (e.g., simulations, case-based learning, role-playing, micro-skills teaching), on-campus clinical experience as well as off-campus experience in different settings is needed. But are all types of clinical education essential? Are they equal in their outcomes? Would it be possible for example to achieve competence having had only 50 hours of face-to-face experience with clients, but a rich array of other clinical learning experiences richly mined to their maximum learning potential and generalizability? Are some direct client experiences more important to target than others? We assume students need to be supervised by speech pathologists but they also must allow for student learning. Clinical educators cannot fulfil both their client and work responsibilities. It is true that some students feel students take time away from core business, and workplaces feel unable to accept students, managers and update their practice as clinical educators.

**Continued use of outdated approaches to clinical education**

Workplace pressures on clinical educators, increased student numbers concurrent with decreased placement opportunities, new goals for clinical education, employer expectations of graduates, and the need to prepare students to work in diverse settings and service delivery models, all necessitate for clinical education and supervision to be done differently. However, there is remarkable inertia or resistance to changed approaches to clinical education in many sectors. Despite research into innovations in placement structure, supervision models and approaches, many programs and clinical educators in the field still hold a belief that clinical educators should be with their students at all times, supervise all student interactions with clients/families, and set aside significant amounts of time each day for feedback, session planning and so on. I would suggest that they still see themselves as “supervisors” rather than “educators”. (See McAllister (1997) for a discussion of the semantics of clinical education and the constraints imposed by adopting a “supervision” rather than “educative” position.)

With continuance of such outdated approaches, it is no wonder then, that clinicians in pressured workplaces feel unable to accept students, managers and update their practice as clinical educators.

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of structuring and managing clinical placements. A number of innovative, but no longer “new” approaches are outlined below.

**Increase the numbers of students per clinical educator**

Ladyshewsky, Barrie and Drake (1998) provided evidence for the benefits of having multiple students placed with one clinical educator, rather than a one student to one clinical educator model. Because of the benefits in terms of peer learning and support, student learning outcomes, service productivity, and more efficient use of clinical educator time, this placement model is now the norm in university on-campus clinics. However, this model also works well in off-campus settings and is now advocated and supported in all Australian speech pathology programs (Callan, O’Neill, & McAllister, 1994; Ladyshewsky & Barrie, 1996), and in some UK programs (Baxter, 2004; Grundy, 2004). Despite the evidence for it, this approach is still regarded as a “new” or concerning innovation in other countries or contexts. Some clinical educators continue to assume (without evidence) that students need one to one supervision, even though they can no longer offer this because of workplace changes.

**Peer learning and peer supervision**

Having more than one student assigned to a clinical educator is not only time and resource efficient, it also promotes student learning, and can help preserve clinical educator sanity. As early as 1979 Dowling was promoting a peer learning technique called the teaching clinic. Since then, peer learning has been mainstreamed in many settings. Student teams are assigned to one clinical educator, perhaps half or one day per week, or on full-time blocks. Students can be at the same level, or mixed junior and senior student teams, as described by Rosenthal (1986). Students and the clinical educator must be good planners of daily and weekly schedules, and be able to manage conflict in the group. Despite the potential pitfalls of peer placements (Best & Rose, 1996; Grundy, 2004), there are considerable benefits (Grundy, 2004; Lincoln, Stockhausen, & Maloney, 1997). Students like peer placements because they can share ideas and resources, provide each other with praise and feedback, and learn from a broader array of clients and experiences than a sole student could manage. Clinical educators like peer placements because they can build in times for student to work together, for example to plan, see clients, provide each other with feedback, freeing the clinical educator to do other clinical or administration tasks. Grundy (2004) provides detailed descriptions of using peer learning with speech pathology students in the UK.

**Different approaches to supervision**

Because of workplace pressures and student numbers, and because it is not educationally sound to use only face-to-face supervision models (McAllister, 1997), clinical educators need to use diverse approaches to supervision and feedback. These approaches could include peer supervision (Rosenthal, 1986), indirect supervision (Baxter, 2004), remote supervision models using online chat or forums (McLeod & Barbara, in press) or tele-conferencing or video-teleconferencing, and supervision shared with other professionals such as teachers in school placements. There has been some research done to evaluate these models of supervision, but they remain largely outside mainstream supervision approaches in speech pathology. They will need to be adopted and further evaluated if we are to meet the challenge of educating more students for diverse practice contexts.

**Managing clinical placements more efficiently**

If individual clinical educators and workplaces are to take more students, clinical placements will need to be managed more efficiently, as time is a scare resource for clinicians. In order to assist clinical educators to better manage the stages of preparing for, implementing and evaluating placements, Romanini and Higgs (1991) developed the Teacher as Manager model. In each stage, the teacher’s roles as task manager, group manager, individual development manager, environment manager and overall program manager are considered. The teacher is encouraged to undertake prior planning and preparation of requirements, possible clients and learning experiences, to plan for the initial encounter with students and to begin preliminary exploration of the learning goals and strategies, and to undertake a preliminary assessment of learner readiness for the placements and its tasks. In the implementation stage, the teacher is encouraged to clarify and plan with students for the attainment of learning goals, organize and manage an array of learning experiences, and continuously review progress with the students. In the evaluation stage, the teacher evaluates the total program – its inputs, processes and outcomes – including assessment of individual students and evaluation of group functioning, and begins to plan for changes in the next placement cycle on the basis of such evaluations. The time spent in pre-placement planning and post-placement review is recouped in smoother running of the actual implementation of the placement.

This section has outlined a number of innovations designed to increase capacity for placements and ensure successful management and outcomes of placements. The fact that some of these innovations are not widely adopted, speaks to the
need for better preparation and support of clinical educators.

Preparation and support for clinical educators

Lack of or inadequate provision of preparation and support for clinical educators is a chronic problem. Since Anderson (1988) noted this to be the case, programs around the world have attempted to improve the content, modes of delivery and outreach of their clinical educator preparation courses and workshops. In the USA, prospective clinical educators can take supervision courses for credit towards higher degrees. In Australia, the University of Queensland (Worrall, Holm, & Cassidy, 1993) has developed a self-directed learning package for clinical educators unable to attend workshops at the main campus. Charles Sturt University offers a Graduate Certificate in Clinical Supervision by distance education. La Trobe University’s Foundation for Quality Supervision has, for over a decade, offered a certificate course for clinical educators at all levels of experience, across a range of allied health professions. This course combines face-to-face contact with self-directed learning materials and workplace based project work. It has reached thousands of clinical educators in Victoria, Australia. The four speech pathology courses in New South Wales, Australia, run a consortium to manage requesting and allocation of student placements and to provide professional development in clinical education. Despite all these innovations, we do not reach all actual or potential clinical educators. We need to coax managers into releasing staff to attend professional development, and better reward clinical educators for updating their knowledge and practices.

We also need to continue to develop new ways to structure and deliver professional development. To do this, we need to be clearer about what it is that clinical educators at the different stages of development from novice to experienced want and need to develop, maintain and extend their skills in clinical education, and to help them implement new practices. My research (McAllister, 2001) into “what is it like to be a speech pathology clinical educator?” provides some direction about preparation and support needs for clinical educators. This research highlighted a range of personal and professional growth needs, including heightened self-awareness, strengthened relationship building and maintenance skills, knowledge of educational theory and strategies, improved skills in assessment of students, empowerment to manage difficult situations, improved meta-cognitive and monitoring skills. Ways of responding to these personal and professional development needs of clinical educators have been discussed by McAllister and Lincoln (2004).

Concluding comments

I have focussed in this article on some of the changes in workplaces and universities which are driving change in clinical education. I have also explored how universities can respond to these changes whilst maintaining the high standards expected of them by professional associations, accrediting boards, and employers. Examples of some innovative responses to these changes and issues are provided. Finally, I have challenged clinical educators to update their practice as educators to accommodate these changes and innovations in clinical education, and considered what universities can do to support their clinical educators to implement change.

There are many other topics which could be addressed in this article, but word length does not permit their discussion in any meaningful way. In addition, topics such as assessment of clinical competence, or the philosophical and theoretical underpinning of clinical education warrant articles in their own right. For recent discussions of these topics see McAllister and Lincoln (2004) and McAllister (2000) respectively. Clinical education always must be a cooperative partnership between universities, clinical educators, workplaces and professional associations. The current issues in the provision of clinical education make the need for creative partnerships of stakeholders even more important.

References


