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INTRODUCTION

At a time when fieldwork education placements in the real world of health care are becoming more scarce universities are looking for other means of providing student placements. University clinics address this need and also provide benefits such as offering community services, developing partnerships with local industry, allowing students to work in professional practice settings with their academic role models and providing a means for academic faculty members to engage in professional practice and professional development.

In this chapter we are using the term university clinics to refer to university-operated health science clinical practice units that both provide health services to the public and provide student placements in actual health care venues. In such units, set up by universities, students and educators are likely to play a more prominent role than in a typical health industry setting, however, the service provision offered by the clinic is an authentic part of the operation of the clinic. In both settings there is a balance to be found between the education and the health care practices and priorities. This will be discussed further below.

A STUDY OF UNIVERSITY CLINICS

We report in this chapter on a research study we conducted to investigate the practices of university clinics across the health and veterinary sciences and develop guidelines for our university for the establishment and operation of clinics. (This chapter will focus on health sciences aspects of the project.) Charles Sturt University (CSU) in Australia provides education across many professions including nursing and allied health. CSU is a regional university, being located across multiple campuses in rural and regional areas of Australia, mainly in New South Wales (See Figure 8.1). The challenges faced by CSU fieldwork education staff in organising fieldwork placements are exacerbated by vast distances, sparse populations and limited numbers of health professionals working in rural and regional areas in both rural cities (populations often below 50,000), small towns
and “outback” areas. Most of Australia's population is concentrated in largely urban population in two widely separated coastal regions, the largest being in the south-east and east. Population density ranges from around 8000 people per sq km in some capital city areas to around 0.2 in remote areas, with the national average being around 3 people per sq km. (See Figure 8.2 for NSW population density 2006). New South Wales covers 800,628 square kilometres (See Figure 8.3.) Placements occur in NSW, interstate and overseas hundreds (and sometimes thousands) of km away from the campus locations where students are enrolled (e.g. Albury-Wodonga).

Rural health science education programs are acknowledged as an effective way of increasing the numbers of health professionals in rural communities (Dunbabin & Levitt 2003; Western Research Institute 2006). However, a scarcity of regional and rural clinical placements limits the ability of regional universities to obtain sufficient workplace locations to place students for clinical education. University clinics can help overcome this shortfall in clinical placements and at the same time deliver quality health services to under-serviced communities.

Figure 8.1 CSU Campuses

Figure 8.2 NSW Population Density 2006
http://www.csu.edu.au/about/maps/

Figure 8.3
NSW area and location
www.google.com
THE PROJECT

This research project was conducted as a consultative inquiry that examined the goals, possibilities and challenges of university clinics by reviewing and critically appraising:

a) documents and literature relating to clinical education models and clinics and

b) 20 existing clinics, across a range of health and veterinary disciplines, associated with Australian and New Zealand universities and private sector health service providers that offer places for students undertaking clinical education.

An advisory group was established to provide discipline-related advice to the project team and to review the draft report and recommendations from the study.

CONSIDERATIONS IN ESTABLISHING UNIVERSITY CLINICS

The operation of a university clinic involves a number of dimensions: education, service delivery, business and finance, and governance (Pope et al. 2008). (See discussion below.) In this chapter, the primary focus will be on the education and service delivery dimensions.

Our study of health and veterinary clinics identified a number of factors which can influence the clinic model adopted by universities: the history and culture of the clinic including the associated professional practice and community expectations; population demographics, the services otherwise missing or less available in the clinic region; the education needs of students; the type of student placement, available infrastructure and funding; the availability of mentors, specialists and teachers; the availability of clients; the location of clients relative to the clinic; the available clinic space and the capacity of the venue for flexible usage. The clinical model, aims, location and procedures will in turn influence the client population attracted to the clinic and the learning opportunities available to students (including such variables as number of clients, range of conditions represented by client group, mode of supervision, background of clinical educator).

From an education perspective University clinics present a number of challenges including: achieving appropriate student preparation for placements; maximising the benefits from learning in a clinical environment; facilitating learning to gain understanding of workplace and community responsibilities, rules and cultures; dealing with changing client populations and client availability; coping with different student needs; and convincing patients that they are receiving quality care from students as opposed to graduate practitioners. The latter requires sensitive marketing, good supervision by competent practitioners, positive outcomes and clinic experiences by patients and appropriate time and space in clinics to enable students to work at their required pace and supervision need. Our project identified that the service delivery dimension of University clinic models must consider a number of key issues:
UNIVERSITY CLINICS

- **The community contexts, needs and markets within which university clinics operate.** Included in these considerations would be the availability of providers, population density, the types of services that are demanded by policy or lobby groups and not yet supplied, and the extent of socio-economic disadvantage in the community (impacting on the affordability of services).

- **The available health care workforce.** The disciplinary focus and potential client group of each University clinic model will determine the likely mix of clinical providers attached to the clinic and the frameworks under which they operate. For instance, it is unlikely that health professionals from local private practices would participate in a clinic that was in direct competition with their own clinic. However, they might be willing and able to support a clinic that provided services to under-serviced populations. This would achieve dual aims of improving health outcomes for the disadvantaged and educating future professionals in their discipline.

- **Available resources and facilities within each location.** Resources and facilities available in particular locations can be a problem in providing services and meeting demand. The problem most frequently noted in our study was that clinic premises were not designed for the dual roles of service provision and education. This limited either the services provided or the number of students able to be supervised or working at any one time. Often clinic facilities were teaching rooms turned into clinics and there were problems with layout and room design. Access for clients was also noted as a problem with stairs, signage, parking and location being identified as barriers to clients locating the clinic or even knowing that it existed. Some clinics also experience problems maintaining equipment, consumables and clinic facilities.

- **The scope/attractiveness of clinics and access to particular services.** Many clinics have problems recruiting enough clients for student needs. This can be a consequence of inaccessible and poorly identified locations within university campuses, sporadic and ineffective marketing, competition from other providers, or lack of a range of client types or problem types in the nearby area. The study also considerable difficulty in matching curriculum requirements with client needs.

In dealing with the dual roles of education & health services provision in University health services clinics, there are many issues for clinic managers, health service practitioners, clinical educators and students to deal with in terms of managing the responsibilities of clinics towards students/the university and clients/the community. Managers and educators need to balance their duty of care to patients/clients and students and to help students balance their learning and service provision responsibilities.
Underpinning university clinic models is an understanding that benefits will accrue to the university, students and clients through the provision of services that also provide clinical education to students. At a societal level clinics provide value through provision of the provision of clinical care and opportunities for health care-related research which will contribute to improving health care quality, availability and access.

In choosing to operate health clinics universities are addressing their commitment to serve the community and therefore accept that the quality of services must be a high priority. The dual role of enhancing the clinical education of students and providing clinical services to clients confronts universities with the challenge of ensuring that their staff and students provide care to clients that meets contemporary quality standards across a range of clinical disciplines. In Australia, for example, The Australian National Health Performance Framework (National Health Performance Committee 2001), divides quality into the four dimensions of safety, responsiveness, capability and continuity.

- **safety**: the avoidance, or reduction to acceptable levels, of actual or potential harm from health care services, management or environments, and the prevention or minimisation of adverse events associated with health care delivery

- **responsiveness**: the provision of services that are client orientated and respectful of clients’ dignity, autonomy, confidentiality, amenity, choices, and social and cultural needs

- **capability**: the capacity of an organisation, program or individual to provide health care services based on appropriate skills and knowledge

- **continuity**: the provision of uninterrupted, timely, coordinated healthcare, interventions and actions across programs, practitioners and organisations (Productivity Commission 2009, Health Preface, p. E.26).

When establishing clinics universities it is important to consider the sustainability of the clinic in order to avoid encouraging expectations that cannot be realised in the longer term through a lack of capacity to provide the necessary infrastructure, to be innovative or to respond to emerging health care needs. Clinics also have an obligation to ensure that quality standards are established and maintained through attention to the service delivery dimensions that unpin the viability and sustainability of university clinics. Table 8.1 demonstrates in a generic fashion how university clinics might consider each of the service delivery dimensions in relation to satisfying this obligation to provide high quality clinical service to clients on the same basis as any other health service provider.
Table 8.1: Quality Standards and Service Delivery Dimensions
(adapted from O’Meara & Strasser, 2002 and Humphreys et al., 2008)

<table>
<thead>
<tr>
<th>Service Delivery Dimensions</th>
<th>Safety</th>
<th>DIMENSIONS OF QUALITY</th>
<th>Continuity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location and infrastructure</td>
<td>Safe working environment for staff, students and clients Co-location may an option</td>
<td>Clinics located to maximise access and equity Public transport availability Disabled access</td>
<td>Contemporary standards for facilities, equipment and information systems. Some technological requirements may be beyond capacity</td>
</tr>
<tr>
<td>Processes of service delivery</td>
<td>Clinical practice standards Risk management policies and processes</td>
<td>Clinics will often be walk-in clinics Operate as interdisciplinary workplaces when possible</td>
<td>With regular clientele booking systems may be required</td>
</tr>
<tr>
<td>Workforce</td>
<td>Students practice under supervision of experienced and skilled professionals</td>
<td>Sufficient staffing (and students) to provide timely services</td>
<td>Academics, clinical staff and students provide services</td>
</tr>
<tr>
<td>Times of operation</td>
<td>Security of staff, students and clients considered</td>
<td>Consider client needs, expectations and ethical issues Manage within business constraints</td>
<td>Hire staff to operate the clinics over student vacation periods?</td>
</tr>
<tr>
<td>Funding</td>
<td>Adequate funding to ensure safe working environment</td>
<td>Adequate budget to allow management flexibility Recurrent budgets to cover salaries and infrastructure</td>
<td>Funding and performance agreements Funded from a variety of sources</td>
</tr>
<tr>
<td>Governance</td>
<td>Clinic accreditation and clinical governance system</td>
<td>Professional and community involvement Appropriate management structures and processes</td>
<td>Clearly defined governance structures and processes</td>
</tr>
<tr>
<td>Integration and co-ordination</td>
<td>Clinical and management information systems</td>
<td>Agreed clinical referral pathways Management and information systems</td>
<td>Key stakeholders identified and roles defined</td>
</tr>
</tbody>
</table>
While there is no absolute best model for university clinics, there is a common need for them to provide quality clinical services and to control the risks to clients, staff and students. Healthcare providers are increasingly emphasising and addressing clinical and professional governance issues to deal with concerns across the health sector and in the community about quality of care, and university clinics need to perform at the same standard in their role as providers of clinical care.

MANAGING RISKS

Primary objectives of university clinics include quality clinical education, service provision and clinical research. Additionally, objectives of such university enterprises include business sustainability, reputation management and regulatory compliance. A risk can be defined (Standards Australia/Standards New Zealand 2004a) as ‘the chance of something happening that will have an impact on objectives’, and that ‘impact’ can be either positive or negative.

Risk management (Standards Australia/Standards New Zealand 2004a,b) for university clinics is complex. In addition to the business risks that must be managed by any organisation, risks associated with clinical practice, patient care and professional competence demand special care (Braithwaite & Travaglia 2008; Irvine 2004). Risks associated with delivery of services by students under supervision and with student education and supervision further complicate the situation. Critical incidents arising from these risks have potential to significantly compromise and damage a university clinic and those it serves. Effective management of these risks requires robust and comprehensive governance arrangements and information systems, which encompass clinical, academic, professional and business governance domains.

A DECISION-MAKING FRAMEWORK FOR ESTABLISHING AND OPERATING UNIVERSITY CLINICS

The flowchart in Figure 8.4 provides a decision making framework developed from our study of university clinics in Australia and internationally, which can be employed when establishing or reviewing university clinics. The framework considers the underpinning values and key objectives we consider are necessary for university clinics, and the contexts in which the clinics are to operate. On this basis, decisions can then be made regarding preferred models for clinical education, clinical service delivery, business and financial management, and governance and risk management. The ‘issues’ element in the decision-making framework is the point in the decision-making process at which conflicts between alternate models are identified and resolved. This is likely to require modification of at least some of the initially preferred models. The weightings given to specific concerns in this phase of the decision-making process should reflect the underpinning clinic objectives, values and contextual sensitivities.
Figure 8.4 A decision-making framework for establishing and operating university clinics (Pope et al. 2008)
CONCLUSION

University clinics provide an alternative and supplement to industry workplaces as a means of clinical education alongside health care services delivery. In the study we have reported issues related to decision making about optimal practice models for the given university/community/health care industry setting have been examined. We have provided findings from our study that emphasises the need for this decision making to be informed by considerations of various interests and imperatives: clinical education; service delivery; business and financial management; and governance and risk management.

REFERENCES


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NOTES  

\(^1\) In this chapter the terms clinical and patient are used to fit with the setting of health sciences clinics  