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Clinical education of BSC OT students by clinical occupational therapists: a mixed methods study

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OT CLINICAL EDUCATOR TRAINING PROGRAMME 2015

WITS UNIVERSITY

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Welcome

Thank you for joining us on this new venture.

This Clinical Educator training programme acknowledges the value, importance and contribution of clinical occupational therapists to the clinical education of occupational therapy students during their undergraduate years. A student's clinical experiences lay the foundation for their professional development, identity, and future practice. In fact some authors have gone as far as to say that:

> "*The future of the profession is dependent on it"*

This Clinical Educator training programme has been designed considering that undergraduate occupational therapy education, in spite of including education strategies to enhance knowledge and skill in our clients during therapy, does not equip therapists with the necessary **educational expertise** to manage the clinical education of students. This is internationally recognised and clinical educator training is recommended and mandated in a number of countries in the occupational therapy world [1].

In the developed countries clinical education of students is a responsibility given to therapists with five and more years of experience. The reality of the South African occupational therapy clinical training platform is that new graduates and therapists with very little clinical experience are responsible for the clinical education of students. This is particularly true on the primary and secondary levels of health care where single therapists or only community service therapists are employed.

Thus this programme aims help the novice occupational therapist to negotiate the complex role and responsibilities associated with the clinical education of occupational therapy students. The programme has been based on a clinical educator 'skills-set' that was developed from an extensive literature review and a survey that was used to determine the clinical education knowledge, skill and value gap between inexperienced and experienced clinical educators.

This programme does not address any profession specific information and only addresses the educational principles and processes required to assist and guide an occupational therapy student to learn, practice and gain an entry level of competence in professional practice.

On–site CE Partnerships: Clinical education roles and responsibilities

	Roles	Responsibilities
Student		
On-site CE		
University CE		
On-site OT manager		
University OT HOD		

On-site senior management		

Indicate which of these roles and responsibilities are:

- Overtly stated
- Assumed
- Falling between the cracks

Making the partnership work:		
	Facilitators	Barriers
Roles, expectations, processes and procedures and responsibilities		
Communication		
Support		
Relationships		

Limitations		

Models of Clinical Education

Different models of clinical education have been described in the professional literature based on a number of perspectives: the theoretical orientation to clinical education, the process of clinical education, and finally, clinical education in relation to the number of students.

Although a variety of models have been described there is little empirical evidence that any of these models support best practice [2]. Joffee suggests that although models provide structure and procedural guidelines, no single model fits all situations, and the diversity of students and their prior knowledge and skills should inform the decision as to which model is used in what circumstances. However there is some evidence that clinical educators have difficulty in adapting their approach when faced with student diversity [3].

Theoretical models of clinical education:

- **No-model Model**

  This model of clinical education is widely used in the health professions. Qualified clinicians become clinical educators by virtue of the fact that they are recognised professionals and are considered to be experienced in the professional field [4]. According to Campbell clinicians have a tendency to supervise and educate in the same way they were supervised and educated as they have no formal training in clinical education. As a result, the education process is often haphazard, with the clinical educator being considered the 'expert' and the student a passive empty vessel that needs to be filled [5]. Campbell describes three variations used by clinical educators within this model: the "*mini–me approach*" where the student is encouraged to imitate and emulate the clinician; the "*one-size–fits-all*" approach where all students are treated similarly regardless of their individuality, diversity or capacity; and finally the "*student as patient*" approach where the clinical education process aims to make "*the student better*" [6].
  Two additional variations to the "No model model" pertinent to health science clinical education have been described: the apprentice model and the collaborative model of clinical education.

  - **The apprenticeship model**

    Historically this was used to teach doctors. Young aspiring physicians worked under the experts, learning their professional skills through 'doing time', observing and learning professional competencies through role modelling [4, 7]. When occupational therapy adopted the medical model, to some extent it also inherited the belief that professional skills were only learnt by 'doing time' under the guidance of an expert practitioner, preferably on a one-on-one basis.

- **Collaborative Model**

  This model is based on the theories of Vygotsky [8] who advocated that adults learnt best through social relationships in a social context in which individuals can learn in their own style using their preferred methodology, but students direct the pace and nature of learning and they are the learning resource for one another. Johnson and Johnson (1991) outlined five principles which support collaborative learning: positive independence, face–to-face interaction, individual accountability, co-operative skills and group processing. All are considered to be important clinical competencies in both occupational therapy and physiotherapy [9-12].

The next group of models will only be discussed in detail in the CE course for more experienced OTs thus only a brief description will be given

- **Psychodynamic models of clinical education**

  Psychodynamic models propose that clinical competence is attained through personal growth through the emergence of self-awareness and self-understanding through transference and counter-transference within the relationship between the student and the educator. These understandings are then applied to the clinical situation to enhance the therapeutic process [13].

- **Cognitive–Behavioural models of clinical education**

  The cognitive-behavioural model of clinical education proposes that students learn professional competencies primarily through role modelling and coaching [4].

- **Developmental Models of clinical education**

  The developmental models of clinical education are widely used in occupational therapy, especially in the USA. These models propose that professional learning follows an incremental pattern over time and with experience. Although professional learning is specific to certain situations, it is also believed to be cumulative in terms of overall experience, and that all clinical learning contributes to the end goal.
  Three models are described in the literature:

  - **Integrated model of development** which is based on the work of Stoltenberg and describes three levels of professional development, each with three stages of growth: self awareness, motivation and finally autonomy
  - **Development as a therapist model**, is based on the work of Ronnestad and Skovholt (2005) and describes six phases of development and fourteen themes [4]. The themes in which development occurs include

integration of professional identity, locus of control, reflection, commitment to learn, reliance on expertise, commitment to professional development and lifelong learning, mastery of professional anxiety, personal–professional life influences, the client as a source of influence, interpersonal sources of influence, affective reaction to old and new members, appreciation of human vulnerability and view of who is the hero in therapy [14].

- **Model of clinical supervision and professional development** was described by Loganbill, Hardy and Delworth in 1982 and consists of three stages that systematically describe the supervisees'/students' view of their development.

  Stage 1 **Stagnation** describes that students are immobilised by insecurities. They do not know what to do but they have a false sense of coping despite an inability to grasp difficulties even if they are pointed out to them. They are often defensive and have a varying attitude to the supervision, from dependence to indifference and antagonism, which makes it difficult to give students the assistance they need to learn.
  Stage 2 **Confusion** is evident in inconsistency as they randomly try to find the right answer and do the right thing without logical process and thought.
  Stage 3 **Integration** is where the student is able to conceptualise the complexities of the problem/situation and generate logical solutions based on theory and clinical reasoning. Students appear to use the clinical education process effectively to facilitate their learning.

- **Schwartz's adaptation of Loevinger's Ego State Development**

  Schwartz, in 1984, reported that stages 3, 3/4 and 4 of Loevinger's model could be applied to the clinical education of OTS [15-17].
  The three levels described are not dissimilar to the levels of action that were described by Vona du Toit in her Model of Creative Ability that is widely used by occupational therapists to guide practice in South Africa [18].
  Level 3: **Conscientious Stage**. In this stage students see the clinical educator as the expert; they want to know the rules and are eager to conform. In this stage students are compliant, do not question the clinical educators' wisdoms and are often passive in the learning process.
  Level 3/4: **Explorer Stage** is characterised by the students demonstrating more confidence and starting to consider more possible solutions to clinical problems. They may challenge the clinical educator's suggestions, and the clinical educator may need to be more open, allowing the student to try more options and reflect on the success of each option without punitive consequence.

Level 4**: Achiever Stage**. At this stage students have mature cognitive skills and can deal with opposing viewpoints, can problem solve and make considered decisions. Students are often hypercritical of their performance and their critique of themselves unnecessarily harsh.

- **Social Role Models**

  These models of clinical education highlight the roles, responsibilities and competencies of the clinical educators and emphasise that they are more than just clinicians who provide learning opportunities for students.

  - **Discrimination model**

    This model is based on the work of Barnard and describes three roles that a clinical educator may use: teacher (to answer questions), consultant (explore alternatives) and counsellor (examines personal issues that may be interfering with the therapy) when assisting students to achieve professional competence.

  - **Double matrix model**

    The double matrix model, also known as the 'seven-eyed model of clinical education' was described by Hawkins and Shohet in 2000 [19] . This model emphasises the role players in the clinical education (the student, patient and clinical educator), the micro and macro context in which the clinical education occurs, and the inter-relationship between these components. nts.

  - **Situational Leadership Model**

    This model has been used in the clinical education of nurses. It is not a model that has been widely reported in the clinical education literature of OTS, which is surprising as it is consistent with occupational therapy practice. This model developed by Hersey [20] is used to motivate and encourage students to perform at their best and uses four different facilitation styles to do this, depending on the readiness of the student to perform including telling/ directing, selling/coaching, participating/ supporting and finally delegating.

Process models of clinical education

These models propose the processes or procedures that take place during clinical education, although according to Nye there is not a lot of understanding of what these processes entail [21]. Two models have been described in the literature:

- **Goldhammer's Supervision Cycle** (1980)

  Goldhammer, Anderson and Krajewski hypothesized that clinical education is a circular process with five distinct stages which occur sequentially [22].

- **Cox's Clinical education model**
  This model was designed for medical education and includes two inter-related and interdependent cycles: an experiential and an explanatory cycle to support the notion that learning and professional practice are based on reflection and critical thinking, rather than just trial and error.
  forward by the student to be used in the preparation of the next session[2, 23].

Models of clinical education related to student numbers

In the last decade professional educators of all the allied health disciplines in the developed world have been increasingly concerned about the rise of student numbers and the escalating difficulty in finding sufficient clinical education sites as well as qualified professionals willing to undertake the clinical education [10, 24]. A number of models have been proposed to deal with the increase in numbers:

The first is the **apprentice model** of clinical education which is described as one educator to one student [25]. This is the model most widely used and favoured by clinical occupational therapists, but is also the model most under threat by staff shortages, workload demands and an increasing number of students [25, 26].
The second model is the collaborative model where **one clinical educator supervises multiple students** [27, 28]. This model is common in single handed occupational therapy practices or where there is a shortage of occupational therapy staff.
The third model is where a **single student is supervised by multiple clinical educators.** Here the student either does the clinical rotation in different sites (one in the morning and another in the afternoon, or different days of the week in different sites or units). The fourth model is the **multiple educators to multiple students model** which is more than one student following a programme described in model three. The fifth model is where OTS are supervised by a **non-education-specific clinical educator [29, 30]** and the final model is **peer supervision** where the students are responsible for the supervision of each other or of more-junior students.
The merits and challenges of each of these models have been discussed by various authors. However a systematic review conducted in 2007 [31] found that the notion that any one model was superior to another was based on anecdotal, personal and historical perspectives and not on empirical evidence. The review concluded that there is no 'gold standard' with respect to a model for clinical education across the allied health disciplines [32] . The choice of model for clinical education therefore seems to be determined by factors such as personal preferences, institutional philosophy and/or staff availability to supervise student occupational therapists.

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