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Supervision of Clinical Education: A Call for a Paradigm Shift

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Clinical education continues to be a concern to many ATs, especially academic and clinical educators and professional leaders. The perception is that although graduates of today have greater knowledge and skills than a decade ago, they don't seem to have the decision making confidence at graduation that previous graduates demonstrated. One reason for this appears to be the nature of clinical supervision during students' professional training. Probable causes of, and possible solutions to, this dilemma are discussed in this issue. It seems clear that we must change our paradigm of clinical supervision; although the details for that change are still to be determined. These articles will help move the dialogue forward.

All seven articles and both letters-to-the editor in this issue address aspects of clinical supervision. Willeford and colleagues developed a series of 6 articles under the umbrella of *Improving Clinical Education Through Proper Supervision*. The seven authors of these articles are veteran clinicians, scholars, and educators. In addition, two authors are members of the *Professional Education Committee/ Council (PEC)* of the *Education Council* and three are *CAATE Commissioners*. They know what they are talking about.

The relationship between these articles is outlined by Willeford, et al in the first of the series, appropriately titled *Improving Clinical Education Through Proper Supervision*. The concepts in these articles are excellent, and if applied by clinical instructors, would be of great benefit to students' education.

In the seventh article, *Is Direct Supervision in Clinical Education for Athletic Training Students Always Necessary to Enhance Student Learning?*, Scriber and Trowbridge call for a relaxing of direct supervision. In doing so, they review the history of AT clinical supervision, discuss the pros and cons of our present model and their proposed alternative model, and discuss some educational theory that supports the suggested alternative.

Students should be encouraged to constantly consider the "how come's and why for's" of their clinical actions, states Charlie Thompson in his letter-to-the editor. Clinical skills and techniques are of little value if we don't know when, how, and why to use them. I must admit that this was a recruited letter. Thompson used this phrase during a discussion on education with the NATA *College and University Athletic Training Committee*, of which he is chair. The concept captures the essence of clinical decision making. Thus, I asked him to put his thoughts into a letter for this issue.

Hawkins raises two interesting points. He suggests that *Clinical Education Coordinator* is a more accurate title than *Clinical Coordinator*. He also feels that the mindset created by a Clinical Education Coordinator thinking of him/herself as a clinical instructor mentor will result in providing more support and education of the clinical instructor. How solid are his arguments?

Development of this Thematic Issue

The topics for six of the articles were conceived by, and developed under the direction of a subcommittee of the *Professional Education Committee/Council*. Willeford and Fincher volunteered to a request from then *PEC* chair Dan Sedory to select some "hot educational topics" and recruit authors to write about those topics for the *ATEJ*. They decided to concentrate on clinical supervision, in part because of some excellent presentations at the 2007 national conference in Los Angeles. They outlined topics and possible authors, and then corresponded with the possible authors about collaborating on some articles. The authors who responded to their invitation joined in developing the specific titles, the content for each article, and who would take the lead in writing each one. Numerous drafts were passed between authors and eventually they submitted them for peer review by the *ATEJ*.

Each of the articles was subjected to independent peer review by the *ATEJ*. We encouraged the *PEC* to undergo this task, but made it clear that there was no commitment to publish any article that could not pass blinded peer review. Each article was peer reviewed by members of the editorial board and guest reviewers, who were unaware of who the authors were, that the paper they were reviewing was part of a specific theme, or that it had been recruited by the *PEC* in response to an invitation from us. As far as each group of peer reviewers knew, they were reviewing a random independent submission to the journal.

Multiple Implications on Clinical Education

The implications of this material on clinical education are at least five-fold: 1) It helps educate clinical instructors so they have a greater understanding of clinical mentoring and student education, and therefore can be more effective in mentoring students; 2) It adds substance to the ongoing discussion of direct supervision, specifically of having graded direct clinical supervision; 3) It has initiated a discussion on whether the phrase "clinical supervision" should be replaced with "clinical mentoring," which conceptually

is really what we do; 4) It suggests that *Clinical Education Coordinator* is a more descriptive title than *Clinical Coordinator* for the educator who coordinates students clinical education; and 5) It suggests that one of the responsibilities of clinical education coordinators is to mentor clinical instructors, with support, help, and encouragement beyond holding yearly or tri-annually Clinical Instructor Workshops.

I highly recommend that clinical education coordinators use these articles as part of their upcoming clinical instructor workshop. One possible approach is to share the articles by Willeford and colleagues with all clinical instructors (download the .pdf files and email them). Assign them to read one article in detail and at least skim the others prior to the workshop. During the workshop, break up into 5 discussion groups to discuss the 5 major articles and how they could apply to those of the group. After a 10-15 minute discussion, reassemble and have a person from each group present a 5-7 minute summary of their groups discussion. Then follow up periodically though the year with clinical instructors about how they are applying the concepts.

These concepts are too valuable to sit in cyber space, or on someone's desk.

Two Additional Considerations

There are two aspects of clinical education that are not discussed in these papers, but are vital to discussions of a possible clinical education paradigm shift: 1) The timing of AT clinical education differs from most other health professions, as do 2) the performance expectations of newly graduated professionals.

In most other health professions students complete the bulk of their didactic education prior to their clinical education. Thus, their clinical education is "full time," meaning they engage in mentored clinical care 8-12 (or more) hours per day. In AT we integrate the didactic and clinical education. Students are engaged much less time per day over multiple years. So the total time spent in clinical education is similar, but its timing is different.

Expectations of graduates differ in that AT graduates are generally expected to "hit the road running." They are expected to be ready to handle all aspects of their job from day one, many without mentoring or with colleagues in close proximity to guide and direct them. In contrast, other health care professions expect less from their graduates, and provide on-the-job training with graduated responsibility. In nursing, for example, graduates spend 4-9 months of on-the-job training before they are fully functioning, independent practitioners.

An Invitation to Dialogue

There are many points in this issue that if implemented, would result in new ways of thinking about clinical supervision; and hence a paradigm shift. We invite letters, pro or con, on these issues. The *ATEJ* should be the repository of the substance of contemporary educational debate and discussion.