

December 2016

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Recommended Citation

Cantatore, Francina; Crane, Linda; and Wilmoth, Deborah (2016) "Defining Clinical Education: Parallels in Practice," *Australian Journal of Clinical Education*: Vol. 1 , Article 2.

Available at: <http://epublications.bond.edu.au/ajce/vol1/iss1/2>

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Defining clinical education: Parallels in practice

Francina Cantatore¹, Linda Crane² and Deborah Wilmoth³

Abstract

What is commonly understood by the term ‘clinical education’? Despite the attraction of a ‘one size fits all’ approach, the concept of clinical education is approached differently in diverse disciplines, which may give rise to pedagogical uncertainty. Clinical education in higher education institutions, previously understood to apply exclusively to health professional disciplines, is no longer the sole domain of medicine and health sciences. Instead, it has evolved into an educational model adopted by multiple disciplines to create and implement experiential learning opportunities for students. For example, in the discipline of law it has given rise to law clinics where students are able to deal with real-life clients and obtain professional experience in interviewing and drafting legal letters and documents under close practitioner supervision. In other areas, such as psychology, clinical education has been implemented as an integral part of the educational model through university clinics and external placements that provide the opportunity to practice clinical skills under conditions of supervision prior to becoming registered as an independent practitioner.

This paper examines the definition of ‘clinical education’ in the diverse disciplines of medicine, law and psychology by drawing on available literature and industry practice, and compares and distinguishes the understanding and application of the term in these areas. It further considers whether a cross-disciplinary approach may enhance and inform practices in different disciplines.

1. Introduction

Clinical education can mean different things to different disciplines. It calls for a different approach in the context of each discipline, which may give rise to pedagogical uncertainty when trying to define what the term means or aspires to do. Clinical education in higher education institutions has been well known and successfully applied in health professional disciplines for some time, but it has also become a focal point of legal education. In short, clinical education has evolved into multi-faceted educational models adopted by multiple disciplines to create and implement experiential learning opportunities for students. This article aims to provide a short description of what the term ‘clinical education’ means – and how it is applied – in three central disciplines, namely medicine and health sciences, law, and psychology. It also identifies and draws parallels between each approach, and examines differences in how these disparate areas of higher education approach clinical education.

A. Medicine and health sciences

Slightly more than 100 years ago Abraham Flexner produced a report on medical education in which he described the fundamental importance of the teaching hospital to the education of future medical practitioners (Flexner, 1910). The core of this model, exposure of students to practising healthcare environments, has endured and today the centrality of clinical education is apparent throughout health professional education. Unlike the key role of the teaching hospital as described by Flexner however, today’s use of the term ‘clinical education’ covers a spectrum of experiences from early observational visits in health care settings, simulated experiences of healthcare cases and situations, and student placements within health care settings in which they are involved with patient care under supervision. Although ‘learning from patient contact’

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remains a fundamental part of clinical education, the location, context and delivery of the educational experiences is changing with an expansion of models from the teaching hospital to additional contexts that provide exposure to the broad range of clinical settings including community, primary care and ambulatory settings (Ash, Walters, Prideaux, & Wilson, 2012).

B. Law

In the context of legal education, Clinical Legal Education (CLE) plays a pivotal role in developing work-related skills and preparing law students for legal practice. The rationale for clinical legal methodology includes the following objectives: CLE has the potential to help students reflect on and analyse their experiences; develop student awareness of law in the context of society; engage students in deep and active learning, with timely, rich feedback; develop student emotional skills, values, responsibility, resilience, confidence, self-esteem, self-awareness and humility; move students towards a responsible professional identity; sensitise students to the importance of all relationships – including with clients, other students, and professionals; benefit from student-centred learning, which arises from flexible and adaptable approaches; and educate students to become effective, ethical practitioners (Evans et al., 2012, p. 5). CLE typically involves students dealing with clients and real cases under the supervision of legal practitioners, and provides opportunities for engagement between the legal profession, the community and law students.

C. Psychology

The educational training of psychologists in Australia has a number of pathways through which a person can train to become a psychologist. For the purposes of this article, the discussion will be about the Masters educational pathway. In psychology, the primary aim of the practical placements is to foster student competency in the following areas: professional knowledge and practice; psychological assessment; planning, design, provision and evaluation of psychological services; report writing; and ethical and legal aspects of professional psychological practice. Students are supervised throughout their practical placements within the University and in community organisations by accredited supervisors who are endorsed in a specific area of practice (clinical, forensic, health, sport, counselling, education and development, and organisational). In completing the practical placement subjects, students will gain the following: application of a sound knowledge base in the field of psychology including psychological theories and models, empirical evidence of theories and models, and key methods of psychological inquiry to manage various client presentations; proficiency to identify and define psychological problems as well as access the research literature and available resources to design, implement, and evaluate research and intervention. They will also acquire the ability to apply professional knowledge demonstrating an understanding of the interaction between the science and practice of psychology across age, culture, and psychological presentation; develop an aptitude to define and specify a psychological problem, gather information through an initial interview, collateral source(s) (if appropriate) and formal psychological tests, generate hypotheses, evaluate findings of the data, conceptualise the case, and write the assessment in a succinct, valid and well organised report. In addition there is a focus on their capabilities to plan, design, provide and evaluate psychological services, including negotiating a treatment contract, provision of psychological services to achieve optimal outcomes, reliable and valid evaluation of the psychological services; knowledge and ability to apply a range of intervention and assessment skills, and micro counselling abilities; competence to communicate effectively via oral and written communication, with clients, other professionals, supervisors, community members and colleagues; application of ethical, legal and professional practice issues such as recognition of service provision boundaries, behaving in accordance with relevant ethical and legal requirements, administrative and record keeping procedures, and undertaking professional development (Bond University School of Psychology, 2016).

2. A discipline-based approach

A. *Medicine and health sciences*

A simple definition of clinical education as ‘health care education conducted in health care facilities, outpatient clinics, emergency centers, hospitals or private offices, under the supervision of a qualified practitioner or teaching staff’ belies the complexity of forms that clinical education can adopt. Most clinical education involves student immersion in the workplace for varying periods of time and as such is analogous to broader constructs of work-based learning or work-integrated learning (Jackson, 2015). In a study of nursing clinical education, Newton, Billett, Jolly, and Ockerby (2016) cited McBrien’s discussion of clinical education as ‘the clinical placement providing opportunities to blend [conceptual and procedural pre-occupational] kinds of knowledge, and transfer them in ways that enhance the development of competent practitioners’ (McBrien, 2006). In emphasising the importance of non-procedural aspects of clinical education within the context of physical therapy (physiotherapy) Rothstein (2002) commented that clinical education ‘should be a time when students develop their abilities to seek knowledge that they can use in the management of patients.’ This broad aim applies equally to all other health professional educational programs. Clinical education is an essential component of health professional education; accreditation bodies require minimum exposure to and immersion in appropriate clinical settings in order for programs to be accredited and students must demonstrate competency in their placements in order to meet the requirements of their degree. Such competency is critical to ensure continuing public trust in health professionals and quality of patient care. The model through which clinical education is provided varies according to jurisdiction and profession. Universities may employ clinically qualified staff in the healthcare setting, negotiate for the healthcare system to provide supervision and resources for an agreed cost, run their own healthcare facilities that provide clinical education to their students, or a mix of all these models. Given this complexity and importance it is unsurprising that issues of cost, effectiveness and accountability of clinical education are major points of discussion as noted by Murray, Gruppen, Catton, Hays, and Woolliscroft (2000).

B. *Law*

In the pedagogy of law and legal skills training, clinical experience is regarded as an invaluable asset for students to enhance learning and to prepare them for legal practice (Cantatore, 2015). In law, CLE is generally defined as a student’s involvement with ‘real clients’ in a legal centre (Campbell, 1991; Bloch, 1982), or in-house campus clinic; or through a placement program or internship (Coss, 1993). In this context the term refers to ‘any law school course or program in which law students participate in the representation of actual clients under the supervision of a lawyer/teacher’ (Bloch, 1982, p. 326). Corker (2005, p. 5) refers to the definition of CLE as:

‘clinical legal education’ involves an intensive small group learning experience in which each student takes responsibility for legal and related work for a client (whether real or simulated) in collaboration with a supervisor. The student takes the opportunity to reflect on matters including their interactions with the client, their colleagues and their supervisor as well as the ethical aspects and impact of the law and legal processes.

CLE has been incorporated in most law schools in Australia. A recent comprehensive review of law school clinics in Australia by Evans et al. (2012), revealed that most Australian law schools had implemented CLE programs.⁴ The report distinguished the following models: wholly law school funded in-house live-client clinics; in-house live-client clinics (some external funding); external live-client clinics (‘agency clinics’); externships (includes internships and placements); and clinical components in other courses (includes simulations of legal practice activities and encounters) (Evans et al., 2012, p. 7).

⁴ According to National Pro Bono Resource Centre (2004, p. 8) ‘clinical legal education programs are available at 23 of the 28 law schools (82%)’.

The report aligned 'service learning' with CLE (Evans et al., 2012, p. 4):

Service learning is a teaching and learning strategy that integrates meaningful community service with instruction and reflection to enrich learning experiences, teach civic responsibility and strengthen communities. CLE shares these objectives and might be considered a specific example of service learning.

Clinical pedagogy generally involves formal assessments during and at the end of semesters. The benefits of clinical training are well-recognised, and it has been found to be consistent with Dewey's curriculum theory and the power of experiential learning, thereby producing 'graduates who can deal effectively with the modern world' (Evans et al., 2012, p. 5).⁵ Goldfarb (2012, p. 301) proposes that clinical legal education is interconnected with the notion of 'personal and social responsibility' within the profession, as well as focused on the transferrable skills pedagogy of clinical education, for example, effective collaboration and communication with other lawyers and clients. Clinical pedagogy also accords with a number of the threshold learning outcomes (TLOs) for LLB and JD degrees, such as ethics and professional responsibility, thinking skills, research skills, and communication and collaboration (Kift, Israel, & Field, 2010, pp. 14, 17, 19, 20).

Castles and Hewitt (2011, p. 91) propose that legal graduates must be equipped with a broader practical skills base: 'first-tier skills' which they describe as 'intellectual and social aptitude including critical thinking and problem solving, oral and written communication, and the capacity to work both independently and cooperatively.' CLE allows students to engage in and develop several of these skills in the context of providing oral and written client advice. Additionally, Curran (2004, p. 174) points to other advantages of clinics for law students; the broader experience base they take into employment and the ability to make a positive impact on policy-making and law reform.

Although there is some overlap, CLE has notably been distinguished from pro bono law clinics (Booth, 2004; Corker, 2005; Evans et al., 2012). Giddings (2008, p. 14) identifies that despite the similarities between 'clinical' and 'pro bono' programs, a definite difference in objectives exists between these two fields. Whilst he acknowledges that the 'practice based context of clinical legal education has the potential to offer a very rich learning environment', Giddings (2008, p. 17) suggests these benefits can be lost in an environment without the necessary supervision or control over casework. In his article on pro bono work in law schools, Grimes (2008) also advocates that '*professionally supervised*' (by legal practitioners) student involvement in practical legal work at university will have a multitude of benefits. Thus, it should be noted that in both CLE and pro bono programs there is usually a requirement for professional supervision to maximise the benefits and increase the learning outcomes for student participants.

Evans et al. (2012, p. 5) also distinguish CLE from 'pro bono publico and student-run volunteer programs':

Such placements have limited educational objectives compared to CLE, do not generally seek to develop students' normative awareness and do not set out to strengthen wider legal education and law reform curricula, although both can awaken and sustain graduates' civic consciousness once they are in practice.

Whilst the reservations expressed by Evans et al may hold true for student-run programs - such as the Pro Bono Students Australia program discussed below - multiple social and pedagogical benefits have been recognised when attached to a pro bono faculty run clinic, with professional

⁵ Experiential learning has attracted the attention of academics in several professional fields, for example, teaching, engineering and pharmacy. Numerous studies have investigated the purpose and value of this learning model, its structure, and its relationship to units or courses as a whole and it is now widely accepted that students need exposure to professional practice to develop critical decision-making skills and to place classroom learning in an authentic context (Taylor & Bates, 2003).

supervision, which has a focus on both community service objectives, and learning and teaching outcomes (Cantatore, 2015). The advantages of such faculty run clinics are numerous – not only do they provide the faculty with experiential learning opportunities for students at a low cost, but they also offer pro bono work opportunities for local legal practitioners, as well as render a valuable community service. Other benefits to students include: interaction with ‘real’ clients and cases; development of social responsibility, empathy and interpersonal skills; networking and integrating with legal professionals; and promotion of ethical behaviour in students (Cantatore, 2015).

C. Psychology

The educational model used in Australia in the training of psychologists is based upon the scientist-practitioner model first put into practice in the United States in 1973. The central goal of the scientist-practitioner model is to train students to acquire both research and clinical skills. It utilises scientifically-based protocols to communicate psychological assessment and psychological intervention measures. Stoltenberg and Pace (2007) identify three roles of the psychologist as a scientist-practitioner: consumer of science, evaluator of science and producer of science. The model supposes that the (psychologist) scientist-practitioner should be capable to read, comprehend and administer relevant research findings, as well as use the scientific approach. The psychologist should be able to apply scientific principles of observation, hypothesis generation and hypothesis testing to each individual patient. This helps ensure that the psychologist uses empirically supported treatments to increase effectiveness and efficiency of their practice. The model requires the psychologist to continuously appraise and modify interventions by measuring efficacy, client progress, and overall success of the intervention (Stoltenberg & Pace, 2007). Finally, the psychologist must contribute new findings derived from their own science to the general and professional communities (Stoltenberg & Pace, 2007). Clinical placement education provides the opportunity to develop and practice these scientist-practitioner behaviours while under the supervision of an approved and endorsed psychologist. Placements include providing psychological assessment, individual and group psychotherapy, and crisis intervention in primary and secondary schools, psychiatric hospitals, community mental health services and community health services as well as within university psychology clinics such as the Bond University Psychology Clinic. Forensic psychology is an area of endorsement under the National Registration Act, along with six other areas. Clinical education provides forensic students with an opportunity to experience the role of psychology in the courtroom and to provide psychological services to offenders with mental health problems in placement settings such as youth justice, alcohol and drug rehabilitation, and prisons. The supervision and expectation of life-long learning continue throughout a psychologist’s career with a minimum of ten hours peer supervision and thirty hours of continuing education required annually.

3. Synergies and diversities in clinical education

From the previous discussion it is evident that, whilst each discipline has a distinct and specialised approach towards implementing clinical education in the higher education context, there are also a number of parallels to be drawn between the different disciplines. Moreover, there may be some overlapping features of certain areas of clinical education, for example the intersection of law and forensic psychology.

A common thread in all three areas is the centrality of practice-based learning and the importance of continuing education, which can be achieved through clinical education and work-integrated learning. These three disciplines also demonstrate that the training for these professional degrees requires immersion into the profession and recognises the critical role that supervision plays in allowing this immersion to occur. The extent to which full-time immersion is a feature of clinical education is variable across disciplines – although it is the norm for health professional courses to include periods of full-time supervised immersion in healthcare settings

it is less common in legal education. Within legal education the use of legal clinics within or strongly associated with the higher education institution is more common although examples of extended immersions have been described with benefits including exposure to the full range of activities in a law firm (Ellman, 2015).

For clinical education in the hospital setting, clinical psychology and medical training often occur together with trainees in each area serving the same patients and engaging in shared care of these patients (Porcerelli, Fowler, Murdoch, Markova, & Kimsbrough, 2013). This interprofessional education has growing support within health professional education and is based on the premise that opportunities for students in the various disciplines to learn together will improve their ability to cooperate and contribute within healthcare teams when they are practising professionals (Buring et al., 2009). Indeed improving teamwork, developing understanding of professional roles and responsibilities, and setting common patient goals are consistently described as the benefits of incorporating interprofessional components into clinical education (Jacob, Barnett, Walker, Cross, & Missen, 2012). Although interprofessional education within health professional education can make a positive difference there are many logistical issues that create barriers to its implementation and success (Barker, Bosco, & Oandasan, 2005). These barriers include differences between current pedagogical frameworks within higher education disciplines, specific professional standards and requirements in different areas of practice, and general resistance to change. Notwithstanding these issues the prospect of greater collaboration between legal and health professional clinical education exists as described by Pettignano, Bliss and Caley (2013) with benefits in developing interdisciplinary awareness and problem-solving which recognise that client/patient problems and issues do not exist in a vacuum, but require a contextual approach.

4. Conclusion

Clinical education is an essential element in the training of professionals in law, medicine and psychology. There are some commonalities in the training of these professionals which supports the recognition of the importance of clinical education to assist students in applying the academic education to the 'real world' of clients and patients. However, more can be done to promote interdisciplinary clinical education between these three professions which would serve to enhance overall training in all three areas. It is these areas which this Journal hopes to promote by providing a dedicated forum for discussion of clinical education across professions. Furthermore, it is hoped that these discussions will lead to recognition of good practice that can be applied across disciplines and as an avenue for exploring interdisciplinary collaborations and synergies.

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