ACAPT Shared Vision for Clinical Education Initiative
JOPTE Special Edition Article Summary

Article Title: Application of Educational Theory and Evidence in Support of an Integrated Model of Clinical Education

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Proposed Clinical Education Position/Model

Clinical education (CE) should include early integrated clinical experiences (ICE) that are closely linked to the academic curriculum and provided by qualified clinical instructors (CI) who are truly dedicated to the educational process. ICE should provide varied active learning opportunities including chances to work in situations not fully covered academically and deliberate guided reflection. Performance expectations should be identified that are commensurate with the student's level of education. While partnership between academic programs and clinic sites is essential, it is the academic program's responsibility to develop, oversee and facilitate ICEs. As such, the academic program is charged with selecting the clinic sites and the CIs as well as building a more intimate relationship that promotes bidirectional information exchange and ongoing clinical faculty development. Academic control over CI selection represents a significant paradigm shift.

Evidence/Rationale to Support Position/Model

The importance of active engagement in context has been supported by educational theorist such as Dewey, Lewin, Knowles, Kolb and Borzak for nearly a century. Literature from multiple health professions including medicine, nursing, and PT have also supported early practice opportunities. The most compelling evidence comes from medical education, which after careful review, has been working to restructure their CE from primarily graduate experiences (internships and residencies) to an integrated approach with CE embedded throughout all levels of medical education to foster knowledge and skill development from undergraduate medical education onward. Multiple benefits have been recognized with the addition of early integrated CE including improved theory to practice linkage, increased student motivation and confidence, more skills practice, and enhanced opportunities for professional, ethical and interpersonal role modeling. Some evidence also exists for improved patient satisfaction when students are involved in their care.

Variations/Flexibility of Position/Model

The authors encourage innovation and provide examples of two different ICE models. In one model, students complete ICE in prescribed settings following didactic coverage of that content area utilizing selected master clinicians who are external to the program's core faculty. Students spend one day/week with their clinical mentor to observe and practice skills and also have a weekly seminar with the DCE to connect didactic and clinical learning. The other model utilizes "in-house" settings with CIs who are part of their program's academic or residency faculty with the expectation that students will practice skills and manage a patient caseload. There are three types of experiences available but in this model, the sequencing of ICE is not directly matched with the didactic content. Both models employed a 2:1 student:CI ratio.

Challenges to Implementation noted by authors

Finding clinical placements for the growing number of students was recognized as a challenge. Suggestions for overcoming this challenge included:

1. Development of innovative models such as peer supervision, peer coaching and interdisciplinary or multidisciplinary placements
2. Increased utilization of the collaborative model (2:1, 3:1, etc.)

The authors also acknowledged the logistic difficulty that academic programs might have with incorporating ICE into their curriculum. Flexibility in course schedule would be needed to allow for clinical time and human resources must be allotted to develop relationships, oversee the ICE, provide training, and continually assess the ICE program.

Gaps in Presentation and/or Challenges to Implementation noted during summarization

No significant gaps noted. The authors do discuss the importance of strong partnerships between the academic program and clinic site but they do not directly address the business management implications that may be of concern with ICE.

Additional Insight/Background to the Position/Model

The American Council of Academic Physical Therapy (ACAPT) has adopted the following terminology for CE:

1. Integrated clinical experience - a clinical education experience that occurs during an academic term in a coordinated fashion concurrent with didactic courses
2. Full-time clinical experience – a clinical experience in which PT students are in clinical environments for a minimum of 32 hours per week prior to completion of all didactic coursework
3. Clinical internship – an extended full-time clinical education experience(s) that typically follow the completion of the didactic coursework for the Doctor of Physical Therapy degree

Questions/Comments in Preparation for webinars/Summit

1. What is the clinic site's administration/management perspective on early ICE? Are there concerns about significant loss of CI productivity with earlier students that are more dependent on CIs?
2. What preparation/training would be recommended for CIs to assist them in adjusting to the lower performance expectations of the early student and the more CI-directed teaching methods required?