Peer Commentary on "Service Delivery and Student Clinical Education: Are the Two Compatible?" by Anne Godden

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As a hospital manager of a Speech-Language Pathology department, I am frequently confronted with the effects of the serious manpower shortage facing our professions. The need for increased training opportunities is apparent in both the university and clinical settings. The Ontario practicum site survey, referenced by Godden in her commentary, revealed that the overwhelming majority of audiologists and speech-language pathologists indeed are highly committed to supervision. In fact "the main obstacles to increasing placements were matters that were beyond the control of the practioners." Shortages of space and personnel were cited as the most significant limiting factors. In the present discussion paper, Godden emphasizes what she perceives as the failure of practicing clinicians to assume sufficient responsibility for providing clinical education.

First, I would agree that, as a speech-language pathologist in a city supporting a training programme, expectations to provide clinical experiences are high. Staff vacancies and turnover are very real obstacles to offering supervision to students twelve months of the year. The single most limiting factor to placing students, however, is accommodating their erratic classroom schedule, which has resulted in repeated requests for block placements. This problem also was noted in the Ontario practicum site survey. If indeed the universities are concerned about ensuring an adequate number of practicum sites, perhaps they could take some direct action to alter the academic schedule. University training programmes offering on-site clinics also might consider utilizing their facilities to their maximum potential, year-round.

Godden discusses the issue of responsibility for clinical education at length but, interestingly enough, makes no mention of a very important stakeholder in this process—the mature, self-directed adult learner, the student. I feel that this relates to Godden's failure to differentiate between gratification and recognition.

In sharing practicum stories with my colleagues over the years, recurring themes regarding gratification emerge. Gratification comes through interacting with a sensitive, motivated, hard-working student who approaches novel, challenging situations as opportunities rather than forms of unnecessary punishment. Gratification is realized in witnessing the personal and professional growth of a supervisee over the course of the practicum and feeling that you played some part. Those of us who have supervised for longer than we may care to admit also know that supervision can be the best of times and ...the worst of times.

Godden's view that "a very high quality of care can be provided by students if they are adequately supervised" is one with which I take issue. The assumption fails to recognize the individual differences among clinicians and the heavy responsibility this places on the supervisor for the performance of the supervisee. This attitude also tends to reinforce the supervisor's feelings of isolation and frustration when dealing with a student who manifests interpersonal problems. The Ontario practicum site survey referred to a study demonstrating a positive correlation between programme admission interview scores and performance in practicum situations, yet the interview practice is not one widely adopted. Does this suggest that the training programmes attach greater value to academic than to clinical performance? Failure to confront interpersonal problems evidenced by students until the time of their externships will continue to erode the positive feelings supervisors derive from the practicum experience.

The Ontario practicum site survey noted that financial renumeration was very low on the list of forms of recognition

suggested by supervisors. Financial renumeration, however, does tend to deliver a powerful message with respect to the value placed on supervision by an institution. As Godden reported, the Department of Psychology at the University of Western Ontario provides renumeration to supervisors in the community. Further inquiry revealed that this has been possible because of the university department's decision to sacrifice a portion of a faculty position to free up funds. Clearly this is recognition. But recognition comes in other, just as significant, forms. It is demonstrated through understanding and acknowledging the day to day responsibilities and stresses faced by those in clinical settings. Godden suggests that "perhaps supervisors sometimes lack the energy to engage in the supervisory relationship;" but this attitude on the part of university staff conveys a lack of support and a lack of recognition for the clinicians' efforts.

Another important source of recognition comes through seeking out and utilizing input from those involved in supervision. The University of Western Ontario has recently invited clinicians to provide input into curriculum planning so that students come to their placements better prepared. This opportunity not only has served as a very positive form of recognition, but also has established additional avenues of communication for faculty and clinicians in the supervisory community. Feedback on performance also is often cited as an example of recognition and has been shown to be related to high morale. However, it is uncommon for supervisors to receive feedback from the training programmes regarding their supervisory evaluations. This information could foster morale as well as assist clinicians in their growth as supervisors.

My fundamental belief is that the university training programmes must take the lead in visibly assigning value to the clinical education of their students. Unless they continue to work with clinicians to resolve some of the practical issues blocking supervisory gratification, a shortage of practicum sites will persist, and this would be a tragedy. Until this day, I still recall one of my early externships which I contend shaped by clinical future. Being part of an environment driven by high levels of enthusiasm, committment, and caring left me with images that are as clear today as they were 17 years ago. I know that because of that experience, I am still able to derive the same measure of gratification from my clinical work as I did then, some 2000 aphasic patients later.
D.L.B.

References

Brodinsky, B. (1983). *Building Morale ...Motivating Staff: Problems and Solutions*. Arlington, Va.: American Association of School Administration.

Godden, A., Bossers, A., Corcoran, D., Ling, D., & Morgan, S. (in press). An Ontario practicum site survey for students of Audiology, Occupational Therapy, Speech-Language Pathology, and Physical Therapy.

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Introduction

Our clinic is not unlike the scenario described by Godden, yet despite long waiting lists, insufficient staffing and pressure to maintain a certain level of productivity, we continue to accommodate approximately 12 student clinicians a year from various universities in Canada and the United States. From a clinical perspective, student clinicians help us to provide optimal services such as group treatment or intensive summer programs, and thus allow us to maintain high levels of quality care with minimal impact on patient attendances. From a personal perspective, the variety in routine and the opportunity to learn and enhance supervision skills helps prevent burnout. Thus, we believe that clinical service and supervision are not incompatible, yet at the same time, acknowledge several of the difficulties presented by the author: the lack of clarity regarding the supervisor's role in the educational process,the amount of clinical time and personal effort involved, and the lack of remuneration to the clinic for this time. In the ensuing discussion, we will discuss these three points, and provide some potential solutions.

Supervisor's Role

Godden rightly points out that the role of clinical supervisors is not clearly defined. Three associated problems arise from this issue: First, supervisors may not see themselves as integral to the educational process or be regarded as such by the university; secondly, supervisors may be uninformed about the content of courses, leading to unrealistic expectations of the student and difficulty assisting the transfer from theory to clinical practice; thirdly, feedback from the university to the supervisor about how he/she fulfills the supervisory role and information about the student's strengths and weaknesses is often lacking. We propose three potential solutions to these problems: a detailed job description, a team approach, and a system for feedback from the university to the clinic.

Job Description

A detailed job description, clearly outlining duties and responsibilities along with estimates of time, would inform supervisors of the expectations of the university and help them to better fulfill their role. Furthermore, the job description should outline the supervisor's role within the whole education and training process in which the student moves from an uninitiated learner to a mature and confident professional. As supervisory commitments vary depending on the student's experience, this job description should be tailored to his/her stage of formation (see Anderson, 1988). For exam-

ple, a beginning student will require a greater commitment of time and effort in order to teach clinical practices (e.g., completing lesson plans), to make the link between theory and practice more salient, and to develop self-evaluation and problem-solving skills. In contrast, a graduating student will be more independent and will rely on the supervisor primarily for consultation. In addition, such a detailed job description would prevent hit-and-miss supervisory practices and ensure consistency of supervision from one student to another (as well as one practicum to the next). Job descriptions would make it easier to maintain clinical sites and solicit potential sites because the commitment and administrative support required would be clear to all.

Team Approach

We believe that the successful education of students requires a team approach in which both university faculty and clinical supervisors view themselves as partners. In this partnership, the supervisor's role is to bridge the gap between theory and clinical practice. Although Godden regards external sites as a strength of the Canadian system, we feel it is at the same time a weakness because external supervisors may not know the course content or the theoretical perspectives that students have been taught. Moreover, courses may not have covered the specific clinical approaches (and accompanying theoretical backgrounds) used in a particular clinic. Thus, the expectations of the university, supervisor, and student may be mismatched, impeding the transfer of theory to skill practice. To facilitate the use of academic knowledge in the clinic, the supervisor must be aware of current course contents. For example, in the area of fluency, the university instructor might liaise more closely with the clinical supervisors who provide practice in this area. Students would benefit from better prepared supervisors, and the faculty member would become aware of clinical approaches and techniques used in external clinical sites.

Feedback

In order to facilitate our roles as supervisors, we require two types of feedback from the university: constructive feedback on our own performance and information on the student's perceived strengths and weaknesses, based on previous clinical evaluations. As supervisors we should welcome feedback on our own performance; it allows us to improve our supervisory skills and continue our professional growth. Not only does it impact positively on the quality of our supervision, but also on our commitment and attitude (i.e., we are also benefitting from participation in this process). The supervisor's role also is facilitated by feedback from the university about the students' strengths and weaknesses. Given this information, we can more effectively match the student' needs with an appropriate supervisory style and the necessary time commitment.

Time

As Godden points out, time is a major factor mediating the availability of clinical sites and the quality of supervision. Initially, we attempted to supervise students and maintain the same high levels of performance, resulting in longer working days and additional stress. In budgeting adequate time, we have learned that students at different stages in their formation require different types of supervisory commitments. As Godden has pointed out, experienced students are sought after by clinics because a consultative style of supervision entails less time. This is entirely consistent with Anderson's (1988) continuum of supervision in which students in the initial two stages (Evaluation-Feedback, Transitional) require a greater investment of resources than students in the self-evaluation (third) stage. Both the direct-active and collaborative styles of supervision, which are characteristic of these first two stages, include skills which are necessarily time consuming (i.e., teaching, demonstrating, analyzing, listening, supporting, problem-solving).

In order to resolve this problem, we have used three major coping strategies. First, we have reduced our normal workloads on the days of student contact in order to free time to adequately attend to the student's needs at different points on the continuum. Nothing is more conducive to stress than the feeling of inadequate time to do a job well. Secondly, we often share the responsibility for supervision among staff clinicians which allows us shorter doses of student exposure in one day or week. In addition, this encourages collegiality among staff clinicians and enhances self-growth through discussion of supervision problems and potential solutions. Thirdly, we have learned to minimize the time required for supervision, particularly of students in stage 1, by being organized with respect to aspects of clinical orientation and clinical procedures. For example, we have an orientation list delineating all aspects of the clinic to which the student should be oriented on day 1 of a practicum. This ensures that all students get the same introduction to the clinical setting and administrative structure, a procedure that would otherwise be haphazard. Also, we have standard forms for lesson plans, which are used by all our supervisory staff, so that a student who has several supervisors need only learn one type of lesson plan form.

While these and other procedures have reduced the time commitments involved through organization, they do not alleviate the cost, in terms of time and manpower, required to supervise, a point which is further discussed below.

Remuneration

There is no doubt that supervision is a time-consuming task. For example, in 1989 we estimated that approximately 389 hours (51 working days) were spent in direct supervision of 15 students by 6 clinicians! The cost of supervision is not negligible and is an issue which must be addressed. Reimbursement is one possible solution to the dilemma between service delivery and student clinical education. As Godden has mentioned, in other professions practitioners are reimbursed for time spent supervising. A comparable arrangement with the Ministry of Colleges and Universities could, in turn, allow administrators of speech and language clinics to hire part-time employees to conduct assessments or fulfill other clinical duties.

L.G. & L.A.

References

Anderson, J. (1988). *The supervisory process in speech-language pathology and audiology*. Boston: College-Hill Press.

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The author has presented with clarity and objectivity an enduring training issue. What was once viewed as a chronic shortage of practicum placements is becoming a contentious and perplexing philosophical controversy. There is no shortage of potentially good placements, but there are definitely a great many clinical professionals who are short on dedication to clinical education. The issue is controversial because many of us believe that practicing members of the profession have a responsibility to help educate new professionals. Obviously this perspective is at odds with that of clinicians who view themselves as responsible only to their clients and their employers. Employing institutions lacking student practicum policies exacerbate the problem. It remains a philosophical matter because no canon exists to supersede pathos. Stakeholders tend to have strong convictions about such issues as responsibility to participate, quality of client care, quality of education, and cost versus benefit. Individuals on both sides spend too much time pointing to examples of the way they think it ought to be and too little time discussing what is best for our professions and the clients they serve. No time at all is spent talking about the things we agree on and ways to make them happen. There is too much conjecture; facts are needed to quiet the dogmatic purveyors of opinion.

Like the author, I find it curious that clinical supervisors, working in similar service facilities with the same kinds of caseloads and with students at the same level of training, can hold opposing views about the worth of students in general. Some view students as an asset; others view students as a liability. As generalities, both views cannot be accurate. A good cost/benefit analysis would point the way to acceptable funding arrangements and deal with the quality issues at the same time. If students are an asset, the service facility should not expect to be financially compensated for its role in the educational process. Instead, it could reapportion staff time to handle clinical education and simultaneously serve more communicatively handicapped clients. If students are a liability, the service facility has a right to expect recognition for its contribution to student training. However, let's state right up front that recognition, which might be partly or entirely financial, would not necessarily come from the academic program. Those who want more speech-language pathologists and audiologists to join the work force must be prepared to pick up the tab.

Clinical service facilities employing speech-language pathologists should have clearly stated policies regarding their committment to clinical education. Obviously, if teaching is not a part of its mission, a clinical service will view participation as a courtesy. However, a mandate to provide clinical service is not necessarily a good reason to refuse to take students; such a position is probably rather short-sighted. Refusal supposes that the professional who does no clinical teaching can serve more clients better, thereby fulfilling the mandate. Although that is true for today, there will be one less graduate tomorrow who might have served many times that number of clients annually during an entire career. Administrators in clinical service facilities throughout Canada should assess their institutions' past, present, and future roles as teaching facilities. Policies must be created to marry a clinical service mandate with an educational program mandate, as well as with any forthcoming guidelines from professional associations.

Professional associations at the provincial and national levels should develop position statements or perhaps even amend their ethics guidelines to stress the importance of members' participation in the clinical education of new professionals. Participation should be obligatory, at least on a conceptual level. Points of negotiation might include the number of students, how often, and special circumstances, but there should be a general understanding that each of us has a responsibility to help perpetuate our own profession. Service facilities that discourage (or fail to encourage) staff participation would surely be in a somewhat uncomfortable position if their employees belonged to a professional association that had mandated their participation in the clinical education process.

In summary, I think two events are requisite to calm the waters: (1) completion of a thorough cost/benefit analysis of the clinical education process, and (2) creation of compatible policy statements from our professional associations and

from clinical service facilities employing association members. Realization of these events will benefit our academic training programs, our clinical service facilities, our profession, and the communicatively handicapped we serve. Failure will leave us with an enduring, perhaps festering, controversy.
P.H.

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As Godden points out in the opening paragraph of her article, Canadian university programs in Speech-Language Pathology and Audiology are facing a serious obstacle to professional education, that is, a shortage of available practicum placement sites. As a director of one of these programs, I have given considerable thought to this problem since I arrived in Canada some twenty months ago. I recognize that my views are likely to be under-informed, but they also may have the virtues inherent in a newcomer's fresh vision and optimism. With this possibility in mind, I am pleased to comment on Godden's discussion.

First, I believe it is important to realize that the underlying educational problem is far from new. Increases in program enrolment coupled with increased service pressures have indeed created new placement shortages. These shortages, however, are only the current symptom of a long-standing failure to recognize the true costs of training speech-language pathologists and audiologists. If we estimate, conservatively, that a student clinician is observed for one-fourth of her/his practicum hours and participates in 80 hours of supervisory conference over the course of two years, then some 16 percent of the student's hours of graduate instruction occurs in practicum experiences. Since practicum instruction, unlike classroom instruction, is wholly individualized, the proportional cost of these instructional hours is even higher. To date, most of the cost of practicum instruction has been born by Canadian service agencies. Since the total number os trainees was small, the absolute cost was small, widely dispersed, and at least arguably offset by gains in professional satisfaction and in the employment pool. It made sense for any given local agency and/or service provider to bear some small fraction of the instructional cost. And they have done so largely without recognition by the ministries and institutions responsible for funding professional education.

The title of Godden's article demonstrates just how dramatically the situation has changed. Higher enrolments have increased the absolute costs of supervision to the point that individual clinicians and agencies are questioning their ability to pay. While service delivery and student clinical education are compatible in principle, they compete in practice. Godden's careful analysis makes it clear that a given clinician cannot increase his or her supervisory commitment and continue providing the same amount of service. If more supervisory hours are needed and services are to be maintained, more resources must be found.

I do not mean by this commentary to reduce the complexities of clinical training to dollars and cents. But I think it is important to separate those issues that are essentially monetary from those that are not. Consider, for example, Godden's question about who is responsible for clinical education. I am frequently asked whether the UBC program intends to open an on-site clinic, with the further suggestion that this would be one way to meet our need for practicum placements. What the questioners fail to recognize is that we too have no budget for clinical supervision. If we did, we could decide whether to open a clinic or subsidize local practitioners to supervise our students. My own preference would be for the latter, since my eleven years of experience in university clinics in the United States has left me greatly impressed by their shortcomings. The point here, however, is that decisions about whose employees should supervise and where this supervision should take place are quite distinct from decisions about who should bear the cost of clinical training. It is only when appropriate financial resources are found that we will be free to create the best possible structures for professional education.

So much for the "fresh vision;" I turn now to the "optimism." Two series of events during the last year have led me to believe that we can eventually solve our clinical placement problems. First, I have been impressed by the degree to which the professional community, in British Columbia and beyond, is willing to work with the school's faculty in finding both short-term and long-term solutions. I and my UBC colleagues do value the many contributions made by our honorary clinical faculty members. We have renewed our efforts to involve them in decision making and strategic planning. They in turn have met our request for a short term increase in the number of placement opportunities.

Long-term solutions would seem to lie in the direction of: (1) curriculum changes to reduce the number of necessary placements and, more importantly, (2) negotiations with pertinent government and university officers to obtain new levels of financial support. My second cause for hope has come from such negotiations. The BC Ministry of Health recently agreed to provide partial released time for several Vancouver speech-language pathologists so that they may supervise the initial clinical practica of our first year students. This model program will allow us to document the true costs of clinical education better and to experiment with new cooperative training frameworks.

UBC has taken important first steps towards solving our clinical training problems, but we, and the profession, are still a long way from a permanent solution. Such a solution will

require the vigorous efforts of professional associations, agency administrators, university personnel, and individual professionals. We must find every opportunity to inform university officials and employing ministries and agencies about the nature and true costs of clinical education. Our first goal should be to insure that clinical instruction is explicitly included in the job descriptions of audiologists and speech-language pathologists. With this recognition we could lobby more successfully for appropriate funding.
J.R.J.

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Many intriguing if not provocative topics are highlighted in Anne Godden's article. In the limited space available to me I wish to comment on two related topics. The first topic deals with the increasing demand for speech and hearing services and the concomitant practitioner supply requirements. The second topic deals with how enhancement of student supervision roles might be associated directly with the need for an increased supply of practitioners. Before proceeding, however, I believe that some of the problems which Godden identifies can be attributed to the seeming dichotomy between the terms *faculty* and *supervisors*. There seems to be a distinction here that may even include a distinction between learning and doing. This unfortunate (and to me artificial) separation of fundamental aspects of becoming and being a practitioner serves to reinforce differences instead of embracing the common goals required in the total education of speech and hearing professionals. I am not criticizing Godden, but I am commenting on a trend that I have seen in many rehabilitation health science programs.

Demands for Speech and Hearing Services

When planning to meet increasing demands for services, the first and almost exclusive approach taken by professions and government is to produce more and more practitioners. While this is an important activity, it is certainly not very comprehensive and can even be described as short-sighted. This is evident when one begins to inspect closely the many complex issues that influence the supply of practitioners. Because of my particular interest in the retention of health care practitioners, I will address what I consider to be one of the most neglected dimensions of practitioner supply: retention of current practitioners.

Looking at the very simplified model used to project supply requirements of practitioners given below it is clear that both anticipated gains and anticipated losses need to be estimated when calculating supply:

Projected supply = current supply + anticipated gains - anticipated losses

Anticipated gains include primarily the production of new graduates, people returning to the work force, and immigration. Anticipated losses include primarily deaths, retirements, emigration, and voluntary withdrawals, including temporary withdrawals (to raise a family, for example) and permanent withdrawals (professionals entering different occupations, stopping work altogether, etc.).

Deaths, retirements, and emigration are considered to be unavoidable losses, while voluntary withdrawals are avoidable and are considered by many to be vastly untapped sources of human health resources (Abelson, 1986). The pertinent question related to this discussion is whether the area of voluntary withdrawal is a source of supply for speech and hearing professionals. If the professions of nursing, occupational therapy, and physical therapy are in any way reflective of the magnitude of voluntary withdrawal among speech and hearing professionals, then, I believe the profession should take a very hard and studied look at retention issues. For example, in Ontario there are data that show that annually approximately 8 percent of physical therapists do not renew their licenses to practice in the province (Annual Report, Board of Directors of Physiotherapy, Province of Ontario, 1989). Translated into numbers, this percentage means that approximately 350 physical therapists do not renew their licenses annually. Put another way, the number of physical therapists produced by Ontario universities annually is less than the number who do not renew their licenses to practice. There are no figures provided in this annual report to indicate the total number of voluntary and nonvoluntary withdrawals from the profession. However, given practitioner demographics and relicensing barriers, it can be assumed that most of the withdrawals are voluntary and permanent.

The response of government and the universities to an insufficient number of physical therapists to meet ever increasing service demands is to produce more and more physical therapists at the undergraduate level. The cost of producing one physical therapist at the undergraduate level is estimated to be about 5.5 times the actual tuition costs that the student pays. In real dollar figures this cost is approximately $45,000.00. Additionally, the cost of replacing employees, including the costs of advertising, interviewing, and selecting the new employee and the costs of the training involved to bring the new employee up to full work load management, has been estimated to be up to 50 percent of his/her annual salary (Cascio & Awad, 1981). It is very important to determine why so many active practitioners are leaving their fields and what, if anything, can be done to stem the tide. This brings me to the second topic I will discuss that was raised by Godden—determining what relationship might exist between

enhancing the roles of clinical supervisors and the retention of these qualified professionals in the work force.

How Enhancing Clinical Programs Might Lead to Improved Practitioner Supply

According to many authors (Mobley, 1977; Abelson, 1986), there are numerous and complex reasons that combine to create voluntary withdrawal. For example, Abelson suggests three generalized sets of factors: individual, organizational, and environmental. (The interested reader is directed to Abelson's excellent article for more details.) For this commentary, I wish to address only those factors that impact directly on Godden's article.

Abelson (1986) states that university affiliation and student supervision can have a positive effect on some practitioners' intent to stay or leave jobs and/or their profession. Clearly, there are numerous, complex contributions and many interactions among the many factors that influence whether someone stays or leaves. I do not want to overstate the possible contribution that enhanced student supervision roles may have on retention, but I do want to emphasize that there can be very positive associations that perhaps are being overlooked.

Clearly some variables associated with influencing stay or leave behaviours are more amenable to change than others, and university affiliation, in its broadest context, is likely to be an influence that can be enhanced. It has been shown that factors associated with improved retention can be incorporated into student education programs. Those factors have been identified by Herzburg (1986) as motivational factors in his motivation/hygiene theory. Interestingly, these factors revolve around two important areas that are inherent in clinical supervision: continued professional growth and development, and recognition for doing a good job. Such factors can be built into the roles for clinical supervisors. For example, supervisors can receive university appointments; they can enrol in university sponsored workshops at reduced fees; a communications network (print or electronic) can be set up to facilitate communication and problem solving; abstracts of current, relevant journal articles can be sent to them on a regular basis along with the possibility of receiving copies of the articles of interest to them at reduced cost; awards such as certificates for supervisory excellence can be established and displayed prominently; they can have increased, active participation in curriculum design and monitoring.

This shopping list is only an initial attempt to identify ways of enhancing the partnership involved in the education of speech and hearing students. Many other creative possibilities exist. Immediately, the question of funding arises. Some enhancements will cost little or nothing. Others might be funded through revenues generated from clinical placement surcharges (i.e., tuition) that students would have to pay. There is sufficient precedent for this in some American health care training programs (e.g., occupational therapy) in which students are charged legitimately for their extended, extramural student practica. Revenues can be used to pay some of the cost of these enhancements and any related university fieldwork coordination.

Summary

I have tried to show that by being sensitive to some of the primary motivators of practitioners, some low cost activities can be implemented that might serve to reward and recognize hearing and speech educators. By doing so in formalized ways, some of these professionals may be encouraged to remain practising for longer periods of time, thereby contributing simultaneously to ever increasing patient care demands and to the education of more practitioners.
S.T.

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Reply to the Commentaries

Reading the five commentaries has left me with a feeling of optimism and excitement: optimism because the authors have made so many concrete and creative suggestions for resolving the current problems and for improving practices in clinical education, and excitement because clinical practicum is clearly receiving serious attention from several directions. Although each commentator has chosen to focus on a different aspect of this issue, there were several recurring themes to which I would like to respond.

One prominent topic was the issue of remuneration. In fact, all of the commentators raised this point for consideration. The diversity of views presented in the commentaries perhaps demonstrates why this has been such a difficult issue to resolve. Johnston and Girolametto and Avery have dramatically demonstrated the significant costs associated with clinical supervision. What is unclear is who should pay for this aspect of clinical education. Trujillo proposes that students might pay, while Bandur suggests that this is the responsibility of the university. Johnston, however, points out that universities may have no budget for clinical supervision, and she points to the provincial ministries of health as one resource. Girolametto and Avery suggest the Ministry of Colleges and Universities might be responsible. I found Hagler's comment intriguing: "Those who want more speech-language pathologists and audiologists to join the work force must be prepared to pick up the tab." But, is this the service delivery agency or the taxpayer who must lobby the government to allocate a sufficient number of tax dollars for this purpose? Bandur reported that one university department uses funds from a faculty position to pay stipends for clinical education. I am aware of one service agency that pays a stipend to its primary clinical supervisor.

The benefits of supervision also remain unclear, and I maintain that these must also be taken into account in any analysis of costs. Girolametto and Avery and Trujillo have added a great deal to this discussion by pointing out how the experience of supervising students might "prevent burnout" and in fact be an asset to the profession in its efforts to deal with problems of retention. Trujillo's interesting analysis leads one to see how focusing greater attention on clinical educators and less on simply increasing the numbers of speech and hearing professionals might help resolve two problems at once. From time to time clinicians seeking a new challenge contact the university to request a student. It might be interesting to look at what types of facilities have the most positive views of student externs. For example, I have the subjective impression that people in sole charge positions frequently are eager to have a student.

The commentaries caused me to think further about the issue of professional responsibility. It seems that no matter what the profession, everyone has benefitted from a teacher, mentor, or supervisor. Bandur described how she had been influenced by one of her practicum experiences, and Hagler stated that "each of us has the responsibility to help perpetuate our own profession." Members of the profession frequently provide in-services to other professionals or serve on committees and executive boards purely out of interest and/or a sense of professional responsibility. The question is: Are these activities any more a professional responsibility than clinical supervision? These kinds of questions, as Hagler suggests, point out the need for a stronger statement on the part of the professional associations. Trujillo's commentary further suggests that we have much to learn from the experiences of those in other professions.

The commentaries of Hagler and Bandur reinforce my original views on the controversy concerning the impact of students on the quality of patient care. Hagler states: "Refusal (to take students) supposes that the professional who does no clinical teaching can serve more clients better, thereby fulfilling the (service delivery) mandate. Although that is true for today, there will be one less graduate tomorrow..." I am not sure that that is even true for today. Perhaps a clinician who engages in supervision becomes a better clinician and consequently serves clients better today. Supervising a student forces one to examine one's clinical beliefs and practices, and as I have said earlier, exposes one to new theories and approaches. I believe that the quality of patient care in both the short- and long-term is enhanced by an agency's involvement in clinical education.

There is however the problem of how to deal with marginal students. I agree with Bandur that greater emphasis needs to be placed on interpersonal skills, and in fact I have had many conversations with colleagues both within and outside the university on how this might be achieved. I am not convinced that interviews with prospective students is the answer. Certainly mistakes in admissions sometimes occur, but I feel that, apart from extreme cases, many of the problems that become apparent in practicum would not be picked up in the admissions interview. There is no question however that difficulty with interpersonal skills is the most common problem reported by supervisors. I do not think that this means that the academic programs do not value clinical performance or interpersonal skills, but it may be that early on in training too much emphasis is placed on the acquisition of knowledge concerning communication and its disorders to the exclusion of experience in the practice or application of

that knowledge and consideration of the impact of interpersonal skills on the clinical process. Pickering (1987) discussed the use of the supervisory conference to teach interpersonal communications. She and her colleague, VanRheenan, determined that three forms of teaching can occur within the context of the conference: provision of information about interpersonal communication, skill training, and modelling. Surely, along with the academic program, the clinical supervisor has a very important role to play in the development or enhancement of clinically effective interpersonal skills.

There are other issues to consider in discussing the impact of the student on a facility. Placement of marginal students causes concern about patient care, may reduce a supervisors enjoyment or satisfaction, and can jeopardize the relationship between the academic program and the service delivery agency. It may seem unfair to an agency to send a relatively weak student out for clinical practicum, and yet more practical experience may be just what that student needs. Sometimes supervisors say that a different type of setting or caseload would be better for a student. However, I cannot imagine that one population of clients is less deserving of quality service than another. The nature of the practicum and the supervision is surely different for the inexperienced or weak student, and, as Girolametto and Avery point out, the nature of the supervisor's job becomes very different. The supervisor likely will engage in much more direct instruction, modelling, and conferencing with this level of student. Some supervisors take pleasure in working with a student that has more to learn, and perhaps, given a fair warning, these supervisors would be willing to work with a student experiencing difficulties.

This leads me to comment on Girolametto and Avery's suggestion that practicum sites be provided with prior information concerning a student's strengths and weaknesses. I agree with them that this information would enable them to plan better for themselves and the student. My own reluctance to provide this information comes from a concern about the effects of bias on the treatment and evaluation of a supervisee. Supervisors can have greater confidence in the objectivity of their evaluations when they have not been provided with this information. In fact, Andersen (1981) demonstrated that supervisors can be biased by prior knowledge of academic and clinical performance. However, there are also drawbacks to withholding information, and the comments here as well as those of supervisors with whom I work are causing me to reconsider my own position on this issue.

Another theme of the commentaries is the communication between the university and the community agency. Again, all of the commentators made reference to the need for improved communication and increased collaboration between these two groups. Many excellent suggestions for what the university can do have been offered. Bandur and Johnston indicated that both the University of British Columbia and the University of Western Ontario are involving community supervisors in curriculum planning. Girolametto and Avery suggest that university faculty could become better acquainted with the clinical practices in use in their community. Community service agencies also can do more by supporting the supervisory process. Hagler discussed the need for facilities to include supervision in their job descriptions and to develop policies regarding clinical teaching. Although many agencies express a commitment to education, supervisors, faced with pressures to maintain heavy caseloads, often fail to feel support for this activity. One hospital administrator recently told me that if she had known that at times the department was refusing to take students, she would have done everything possible to relieve pressures and assist the supervisors in this task. Perhaps clinic administrators are not clear enough in communicating how they can provide support for clinical education, or clinicians do not feel they can ask for this support.

Trujillo's eloquent comments on the trend to perceive a dichotomy between faculty and supervisors and on the "distinction between learning and doing" should cause all of us to pause and reflect. Girolametto and Avery also talk about the need for partnership. Surely the university and the clinical service facilities and supervisors would like to see the same outcome: growth in the numbers of highly skilled professionals capable of providing quality care to clients, of developing new approaches or programs of service delivery, of promoting the profession, and of advancing the knowledge base in the discipline.

The dichotomy between scientist/researcher and clinician/practitioner is not new. However, I was struck, particularly in reading the commentaries by Bandur and Hagler, that somehow each side, in struggling to meet the ever increasing demands both for education and service delivery, has come to the conclusion that clinical practicum is not valued by the other side. When supervisors decline to take students, the university feels the facility does not place enough value on, or is not committed to, clinical education. When supervisors feel their efforts are poorly recognized by the university, they feel that clinical practicum is not valued by the university. Bandur suggests that "the university programs must take the lead in visibly assigning value to the clinical education of their students." I continue to maintain that these are not just the universities' students and that the universities and the clinical facilities are not the only partners. Insufficient resources and unclear professional expectations also have contributed to this dilemma. The professional associations and the government ministries also must do more.

It is encouraging to note that some steps are being taken by all of these partners. Some community agencies are allow-

ing time for clinical supervision and for supervisors to participate in academic program planning. The universities are seeking that input and are exploring funding alternatives. Johnston mentioned the support of the British Columbia Ministry of Health. In Ontario, the Ministry of Health has provided funding for workshops on supervision, visits to practicum sites by university faculty, and a survey of practicum site resources and concerns. The national association, CASLPA, is establishing greater links with the universities and has supported the formation of a Supervision Interest Group. However, it is clear from these commentaries that much remains to be done.

My goal in writing this article was to stimulate discussion on these complex issues. The commentators have contributed thoughtful and intriguing ideas to this discussion and have provided further food for thought. I hope the debate will continue and that through on-going communication many of these problems will be resolved.

A.G.

References

Andersen, C. (1981). The effect of supervisor bias on the evaluation of student clinicians in speech-language pathology and audiology. (Doctoral dissertation, Indiana University, 1981). *Dissertation Abstracts International, 41*, 4479B. (University Microfilms No. 81-12,499).

Pickering, M. (1987). Interpersonal communication and the supervisory process: A search for Ariadne's thread. In M. B. Crago & M. Pickering (Eds.), *Supervision in human communication disorders: Perspectives on a process*. Boston: College-Hill Press.