
Effects of Giving Practicum Supervisors Information About Their Students' Skills

Incidence des renseignements relatifs aux aptitudes des élèves sur les directeurs de stage

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Abstract

This study tested the effects of providing lists of students' clinical competencies to practicum supervisors. Subjects were 29 supervisor/student pairs who were randomly assigned to experimental and control conditions. Experimental group subjects received a clinical practicum competencies list relevant to the experience level of their current student. Impact of the lists on students' evaluations was measured with W-PACC scores. Impact on subjects' satisfaction with the practicum experience was measured with a 16-item questionnaire. Results indicated that clinical competencies lists did not reduce variance in evaluation scores nor increase participants' reported levels of satisfaction. A lack of impact on experimental group subjects is discussed in terms of possible limitations in the experimental procedures and in the tools used to measure the dependent variables.

Abrégé

L'étude devait établir quels effets la distribution d'une liste énumérant les compétences cliniques des étudiants aurait sur les directeurs de stages. Vingt-neuf paires de sujets combinant directeur et étudiants ont été réparties au hasard entre le groupe expérimental et le groupe témoin. Les sujets du premier groupe ont reçu une liste des compétences cliniques correspondant à l'expérience de l'étudiant. On a déterminé l'incidence de la liste sur l'évaluation des étudiants au moyen de la cote W-PAAC. Son incidence sur le degré de satisfaction des étudiants à l'égard du stage a été mesurée grâce à un questionnaire à 16 points. Les résultats révèlent que la liste des compétences cliniques ne réduit pas la variance de la cote obtenue à l'évaluation et n'augmente pas le degré de satisfaction des participants. On tente d'expliquer l'absence d'impact sur les sujets du groupe expérimental par les limites éventuelles de la méthode expérimentale et des instruments utilisés pour mesurer les variables dépendantes.

North American university training programs in speech-language pathology rely on community professionals to provide the majority of the clinical training component in

their programs. Typically, students experience several different placements in the course of a training program. These placements usually differ considerably from one another in ways not related to the obvious institutional and case load variations. Other factors that may contribute to inconsistencies across practicum placements are professionals' diverse backgrounds, professionals' varying levels of supervisory training, and differences among supervisors' interpersonal styles. There is probable variability in the demands placed on students of a given level of training. It is reasonable to believe that the degree of congruence between student expectations and placement demands will affect participants' levels of satisfaction. For example, if demands are unrealistic or unexpected they might have a deleterious effect. These same diversity factors may also contribute to questionable consistency in grading. The problem seems to be that an absence of general, experience-related criteria forces supervisors to rely on individually devised, internal yardsticks in their attempts to judge each student's competencies.

Diversity in settings, case loads, and participants' backgrounds are essentially desirable, because they contribute to a well-rounded clinical education program, which better prepares new professionals to join the work force. However, when diversity is combined with a lack of uniform criteria as a basis for what to expect and how to evaluate what is produced, the deleterious effects may be twofold. Perceived satisfaction of the supervisor and student may suffer, and quality of the clinical education process may be compromised.

Although competency-based systems of instruction and evaluation have been recommended (Rassi & McElroy, 1992), most clinical training programs do not routinely provide supervisors and students with such information prior to each practicum. Rassi and McElroy recommended identifying, sequencing, and monitoring clinical competencies at designated check points in an audiology training program.

Rassi and McElroy suggested that by doing this, participants are better able to understand the clinical and supervisory processes, identify skill gaps that need filling before moving on to a more advanced level, and engage in more goal-focused discussion and evaluation of progress. In the absence of such information, supervisees may not know what their supervisors will expect of them, may perceive themselves to be unfairly judged, and may leave the placement experience with hard feelings. In the absence of clinical competency information, supervisors may be uncertain about what to expect, may judge students' performances unfairly, and may experience dissatisfaction with the supervisory process. In addition, without standard criteria, there may be unnecessary variability in student performance evaluation across practica. Thus the entire clinical education process may be adversely affected in a variety of ways.

Previous research (Andersen, 1981) identified certain types of information about students that should not be shared with supervisors. In a tightly controlled experimental design, Andersen found that supervisors were biased by knowledge of their students' grade point averages and previous supervisors' evaluations. When supervisor subjects were told that students' grades were high or that students had done well in their previous placement, they scored the students' clinical work high. Conversely, when supervisor subjects were told that students' grades were low or that students had done poorly in their previous placement, they scored the students' clinical work low. However, information about the extent of students' previous clinical experiences did not bias supervisors' judgement of students' clinical performance. Those findings suggest that information about student performance should be judiciously dispensed to supervisors and that two types of information, grades and clinical evaluations, probably should be off limits. Andersen's study did not attempt to assess the value of the non-prejudicial descriptive information it provided, nor did it examine the effects of other types of information about students.

It is important to know which types of information are non-prejudicial, and therefore safe to share, but it is equally important to be able to say which among the safe types of information are beneficial to the participants. It is also important to remember that both supervisees and supervisors can provide one another with potentially useful information. Who should give what to whom deserves careful study.

Supervisees may benefit from shared performance expectations in two ways: (a) by understanding their own responsibilities and (b) by trusting their supervisors. Both are believed to be related to performance effectiveness. Leith (1989) suggested that supervisees should know specifically what behaviours they are expected to perform. It was Leith's opinion that, when information is available, supervisees feel

more secure in their clinical interactions with their clients and supervisors because the "ground rules" are established. The implication is that supervisees will take responsibility for those skills listed as characteristic of their level of training. A key aspect of effective performance is a relationship of mutual trust (Neagley, 1980). If the goal of the supervisory process is to facilitate professional growth, it is reasonable to believe that this will happen most efficiently in a trusting relationship. Such a relationship can be built on a foundation of common expectations.

If supervisors and supervisees operate from different sets of assumptions about what should take place between them, communication barriers are raised even before their interaction begins (Blumberg, Amindon, & Webster, 1967). Discrepancies between expectations and perceptions of what actually happened lead to confusion and conflict. It has been suggested that individuals experiencing such conflict are less effective than others (Cooper & Good, 1983; Getzel & Guba, 1954; Trow, 1960). These authors believed that "effectiveness" could be defined in terms of how well one party perceived the other to fill the expected role. Trow discussed the conflict that can arise between teachers and their administrators, suggesting that where a teacher's behavior is at odds with the administrator's expectations, the teacher's performance may be judged to be unsatisfactory. In their discussion of the teacher/student relationship, Cooper & Good went one step further suggesting that situations characterized by role conflict can become self-fulfilling prophecies in which students live down to the negative expectations of their teachers. Anderson (1988) summarized the work of several authors on the importance of shared expectations. It was broadly believed that shared expectations were "...an important prerequisite to communication and to meeting objectives, especially in the supervisory relationship" (p. 71).

Setting aside the dyad as a source of inconsistent expectations, one can look at supervisors' expectations as they relate to a given student. Inconsistent expectations may cause different supervisors to perceive the same student as having very different levels of competency across the same skill and knowledge areas. This may manifest itself in highly variable clinical evaluation scores. Hagler and Fahey (1984) reported such scores to be highly variant and suggested that this could be attributable, in part, to differences in individual supervisors' expectations.

Like most training programs in speech-language pathology, the University of Alberta does not provide field supervisors with a list of specific clinical competencies appropriate for different practicum levels. A number of supervisors had indicated that such a reference list would be appreciated, and it seemed reasonable to believe that having one might: (a) result in greater uniformity in performance

evaluation, and (b) clarify for both the supervisor and supervisee certain clinical expectations at the outset of the practicum, thereby increasing supervisor and supervisee satisfaction with the clinical education experience. Therefore, this pilot study attempted to answer the following questions:

1. Will a list of students' clinical competencies provided for supervisors at the beginning of a practicum reduce variance in grading?
2. Will a list of students' clinical competencies provided for supervisor/supervisee pairs at the beginning of a practicum increase supervisors' satisfaction?
3. Will a list of students' clinical competencies provided for supervisor/supervisee pairs at the beginning of a practicum increase supervisees' satisfaction?

Variables. This study attempted to answer the above questions with one independent variable and three dependent variables. The independent variable was the Clinical Practicum Competencies (CPC) list, which has two levels: provided and withheld. Two forms of the CPC (Appendices A & B) were developed, each specific to a particular level of student experience. The dependent variables were: (a) W-PACC, the average score on the Wisconsin Procedure for Appraisal of Clinical Competence (Shriberg et al., 1974); (b) Supervisor Satisfaction, the level of satisfaction derived from the Supervisor Satisfaction Questionnaire (Appendix C); and (c) Supervisee Satisfaction, the level of satisfaction derived from the Supervisee Satisfaction Questionnaire (Appendix D).

Method

Subjects

Twenty-nine female speech-language pathology supervisor/student pairs volunteered to participate in this study. All supervisors participated until completion. Twenty-six worked in Edmonton and the surrounding area, and three worked in a clinical service facility in the United States. Supervisors' years of experience ranged from 2 to 17, with a mean of 7.5 years of experience. The number of students they had supervised prior to this study ranged from 1 to 15 with a mean of 4.7 students. Supervisors reported differing amounts of continuing education related to clinical supervision. Some had none, and others had various combinations of independent reading, workshops, and credit courses in clinical education.

Twenty-eight student clinicians, ranging in age from 20 to 34 years, participated to completion. All were University

of Alberta undergraduate students. Fifteen were interns between their third and fourth years of study (Level III). The number of practicum hours they had obtained prior to the placement during which they participated in this study ranged from 44 to 198, with a mean of 74.2 hours. Thirteen were in their second term, fourth-year practicum placements (Level IV). The number of practicum hours they had obtained prior to the placement during which they participated in this study ranged from 60.5 to 360, with a mean of 266.4 hours. The mean number of hours for the combined experience levels was 175.5.

Materials

The Clinical Practicum Competencies (CPC) lists (Appendices A & B) were created by the investigators in collaboration with experienced clinical supervisors and students. They were designed to provide basic information relating to the student's background and clinical readiness skills. There was some provision for individualized student information, but both forms were intended to be generally descriptive of the respective skills of the two levels of students who participated in this study.

The Wisconsin Procedure for Appraisal of Clinical Competence (W-PACC) (Shriberg et al., 1974) was used as the index of student performance from which grading variance measures were derived for comparison. The W-PACC is a 38-item evaluation form that asks supervisors to score their students on a 10-point scale of independence on each item. Items describe a variety of professional-technical and interpersonal skills that are commonly believed to be important to overall clinical competence.

Materials for the measurement of treatment effects were the Supervisor Satisfaction Questionnaire (Appendix C) and the Supervisee Satisfaction Questionnaire (Appendix D). Both questionnaires were created for this study. Questionnaire items were specifically designed to measure supervisors' and supervisees' general levels of satisfaction with the placement experience, as well as their attitudes toward issues such as expectations, evaluation, independence, and information-sharing.

Procedure

Tool validation. CPC lists were validated by presenting them to selected students and supervisors for their feedback. A minimum of three students and three supervisors, who were knowledgeable about the purpose of the study and the intent of each tool, were asked to examine them and suggest changes that would make each tool more consistent with its intended purpose. This type of face validity is all that was sought for this pilot study. Satisfaction questionnaires also had face validity prior to their administration. Validity was

implied on the basis of a loose adaptation of content and format from two previously validated rating scales for the measurement of supervisory process interaction (Powell, 1987; Smith, 1978). This was done with the expectation that data accruing from these questionnaires would be factor-analyzed to assess whether the intended underlying constructs were adequately represented.

Experimental groups and conditions. Supervisors and supervisees independently volunteered to participate and were randomly assigned to experimental and control groups. There were 15 experimental group supervisors and 14 control group supervisors. There were 15 experimental group supervisees and 13 control group supervisees. Prior to, or near, the beginning of their practica, experimental group participants received the appropriate CPC list and a cover letter explaining what was required. Control group participants received a cover letter only. Both groups were asked to complete satisfaction questionnaires within one week of completion of the W-PACC. Supervisors completed the Supervisor Satisfaction Questionnaire (Appendix C), and supervisees completed the Supervisee Satisfaction Questionnaire (Appendix D).

Design and analyses. This was an experimental pilot study using a between-groups design with administration of a Clinical Practicum Competencies (CPC) list as the independent variable having two levels: provided and withheld. Data for question no. 1 were analyzed with a test for homogeneity of variance (Bruning & Kintz, 1977). Independent samples *t*-tests were used to answer questions nos. 2 and 3. Analyses were carried out using *StatView SE+ Graphics* (Feldman, Hofmann, Gagnon, & Simpson, 1988).

Results

Question no. 1, which pertained to potential reduction in practicum grading variance, was measured with three tests for homogeneity of variance (Bruning & Kintz, 1977). These tests compared the variances of experimental and control groups in terms of Overall W-PACC score, $F(13, 12) = 1.8$, Interpersonal Skills Score, $F(13, 12) = 2.1$, and Professional Technical Skills Score, $F(13, 12) = 1.5$. The critical value of $F(13, 12)$ with $p = .05$ was 2.69. Results indicated that variances for the two groups did not differ on any of these parameters; therefore, experimental and control groups were considered homogeneous with regard to practicum grading.

Factor Analysis

To answer questions no. 2 and no. 3, which pertained to potential increases in participants' satisfaction as a result of

receiving a competencies list, independent samples *t*-tests were required. However, before beginning tests for significant differences, it was important to establish content validity of the two satisfaction measurement tools (Appendices C & D) and designate specific underlying constructs for comparisons. This was done using factor analysis with a varimax orthogonal transformation solution available in *StatView SE+ Graphics* (Feldman et al., 1988). Separate factor analyses were carried out on questionnaire data from all four groups: supervisor experimental, supervisor control, supervisee experimental, and supervisee control. This was done for two reasons: (a) a concern that the experimental condition might have caused different response trends between experimental and control group subjects, and (b) supervisors' and supervisees' inherently different views of the process might have caused different trends.

Factor analyses of supervisor data revealed two factors common to participants in experimental and control groups. Variability was evident among the items loading on each factor for experimental and control groups. Therefore, in order to make relevant comparisons, only loadings common to both experimental and control groups were considered. The first factor seemed to be Applied Academic Training. It was consistently represented by questionnaire item no. 7, loading .931 on Factor 1 for the experimental group and loading .794 on Factor 4 for the control group. The second factor, which seemed to be Discussion and Summary, was consistently represented by two items: (a) questionnaire item no. 13 loading .972 on Factor 3 for the experimental group and loading .877 on Factor 2 for the control group, and (b) questionnaire item no. 14 loading .895 on Factor 3 for the experimental group and loading .934 on Factor 2 for the control group.

Factor analyses of data from supervisees revealed three factors common to participants in experimental and control groups. Variability was evident among the items loading on each factor for experimental and control groups. In order to make relevant comparisons, only loadings common to both experimental and control groups were considered. The first, which seemed to be Discussion and Summary, was consistently represented by two items: (a) questionnaire item no. 13 loading on Factor 2 at .933 and .966 for the experimental and control groups respectively and (2) questionnaire item no. 14 loading on Factor 2 at .949 and .946 for the experimental group and control groups respectively. The second factor, which seemed to be Supervisor Expectations, was consistently represented by questionnaire item no. 15 loading on Factor 1 at .896 and .947 for the experimental and control groups respectively. The third factor, which seemed to be Requests for Clarification, was consistently represented by questionnaire item no. 11 loading on Factor 3 at .956 and .987 for the experimental and control groups respectively.

The communality estimate represents the amount of variance for each questionnaire item that can be explained by the four factors. Tatsuoaka (1971) recommended omitting any items with a communality estimate below .3. All of the above items had a communality estimate above .79, therefore none was excluded.

In summary, four constructs were revealed. One underlying construct, Discussion & Summary, pertained to potential increases in participants' satisfaction as a result of receiving a competencies list, and related most closely to research questions no. 2 and no. 3. This construct overlapped for supervisors and supervisees. One underlying construct, Applied Academic Training, was unique to supervisors. Two underlying constructs, Supervisor Expectations and Requests for Clarification, were unique to supervisees. These four constructs were used for difference comparisons. Even though questionnaire item no. 16 was intended to directly address participants' satisfaction with the practicum experience, it was not revealed by factor analysis to reflect an underlying construct shared by any of the experimental or control group participants. None of the other questionnaire items met the criterion of being common to experimental and control groups, and were therefore not used for between-group comparisons.

Experimental Effects

Questions no. 2 and no. 3, which pertained to potential increases in participants' satisfaction as a result of receiving a competencies list, were answered with independent sample *t*-tests. These comparisons, between the supervisor/student group that received competencies lists and the supervisor/student group that did not, were made with students collapsed across experience levels. Dependent variables were derived by averaging individual respondents' raw score ratings on the top-loading items that comprised each of the factors described above.

Supervisors. The two dependent variables derived from supervisor satisfaction questionnaire data were: (a) Applied Academic Training, and (b) Discussion and Summary.

Tests for mean differences between experimental and control group supervisors' perceptions of students' application of their academic training revealed that experimental group supervisors ($M = 5.53$) did not differ significantly, $t = -.388$, $p = .70$, from control group supervisors ($M = 5.71$). Tests for mean differences between experimental and control group supervisors' perceptions of whether students' clinical abilities were discussed and accurately summarized revealed that experimental group supervisors ($M = 11.07$) did not differ significantly, $t = 1.70$, $p = .10$, from control group supervisors ($M = 9.57$).

Supervisees. The three dependent variables derived from supervisee satisfaction questionnaire data were: (a) Supervisor Expectations, (b) Discussion and Summary, and (c) Requests for Clarification.

Tests for mean differences between experimental and control group supervisees' perceptions of supervisor expectations revealed that experimental group supervisees ($M = 5.73$) did not differ significantly, $t = -.857$, $p = .20$, from control group supervisees ($M = 6.17$). Tests for mean differences between experimental and control group supervisees' perceptions of whether their clinical abilities were discussed and accurately summarized, revealed that experimental group supervisees ($M = 9.80$) did not differ significantly, $t = .265$, $p = .40$, from control group supervisees ($M = 9.42$). Tests for mean differences between experimental and control group supervisees' perceptions of whether they had requested clarification revealed that experimental group supervisees ($M = 6.47$) did not differ significantly, $t = 1.365$, $p = .09$, from control group supervisees ($M = 5.85$).

Discussion and Conclusion

Impact on Grading

It was concluded that a list of students' clinical competencies provided for supervisors at the beginning of a practicum did not cause a reduction in grading variance. The assumption was that supervisors who used their own internal indices of student competencies might have been more variant in their evaluation of student performance than supervisors who were provided with a common basis for their expectations. There are five possible explanations for this lack of effect. One may be that the competencies lists lacked the specificity necessary to enable supervisors to formulate impressions pertinent to the end of term evaluation tool. Another possibility is that participants might not have summarized and discussed the competencies lists thoroughly enough to provide a specific profile of the students' clinical capabilities. It is reasonable to believe that detailed consideration, individually and collaboratively, of such a list would be necessary for it to have an impact. A third possibility is that the experimental group supervisors actually developed a common set of expectations as a result of having received the competencies lists, but that the W-PACC, from which the dependent variable was derived, was insensitive to the differences in group expectations. A fourth possibility is that any inherent stability in the W-PACC may have been lost through inconsistent application by supervisor participants. Finally, there is the possibility that competency lists may not affect grading, that information about students may not be critical to the evaluation process.

Impact on Satisfaction

Supervisors. It was concluded that a list of students' clinical competencies provided for supervisor/supervisee pairs at the beginning of a practicum did not cause an increase in supervisors' satisfaction. There are six possible explanations for this lack of effect. The first explanation is that the satisfaction questionnaire may not have been sensitive to supervisors' actual levels of satisfaction. The factors "Academic Training", supervisors' impressions of the extent to which students applied academic information, and "Discussion and Summary", supervisors' impressions of the extent to which students' clinical abilities were discussed and summarized at the beginning of the practicum, would not be considered by most of us to be indices of satisfaction.

A second possible explanation for the absence of increased supervisor satisfaction is the possibility that a competency list simply did not have an impact on satisfaction. In other words, it may have been an invalid assumption that supervisors would realize greater satisfaction as a result of knowing more about their student's pre-placement competencies. From conversations with supervisors over many years, the investigators had come to believe that supervisors' expectations were often incongruent with students' abilities. When such problems were encountered, it seemed to relate to supervisors' expectations exceeding students' abilities. In turn, this may have resulted in supervisors' dissatisfaction with students' performance. As administrators, the investigators were concerned that these supervisors would become dissatisfied with the clinical education experience as a whole. Perhaps this was not the case; perhaps giving supervisors pre-placement competency information does not result in increased satisfaction, but rather in more informed supervision. The latter, of course, was not measured. It is noteworthy that supervisors tended to rate themselves as very satisfied with the clinical education experience, with or without additional pre-placement competency information.

A third possible explanation for the absence of increased supervisor satisfaction is that experimental group supervisors did not have enough information to adequately apply the lists of clinical competencies to their individual students. Supervisors might have benefitted from additional information from either of two sources, the students or the investigators. The unembellished lists may have been too generic to be useful. The CPC list might have had greater impact if students had been coached to provide pertinent additional information about themselves. It also might have had greater impact if the investigators had provided a tutorial to supervisors via a descriptive attachment, a short in-service, or by phone.

A fourth possible explanation is that supervisors may not have received the competencies lists soon enough to

incorporate their contents into placement planning. Early placement is a busy time, with much extra work. Earlier receipt would have left more time for questions, clarification, and supervisor/supervisee meetings.

A fifth possibility is that the CPC actually had the desired effect, but that the attempt to measure the effect was too late. Perhaps the CPC increased participants' satisfaction shortly after it was made available, in the early stages of the placement. This impact might not have been measurable weeks later at the end of the placement and, as noted above, all groups of participants reported generally high levels of satisfaction at the end.

A sixth and final possibility is that the competencies lists were introduced with insufficient direction and support from the investigators. If the students had been coached about how to individualize the generic competencies lists, the lists would perhaps have provided more meaningful information for the supervisor. If either participant, or both, had been provided with strategies for ensuring that the lists were thoroughly discussed, the lists might have been given more attention and thus might have had a greater impact.

Supervisees. It was concluded that a list of students' clinical competencies provided for supervisor/supervisee pairs at the beginning of a practicum did not cause an increase in supervisees' satisfaction. It probably was not reasonable to believe that providing supervisors with information about their students would result in the students' satisfaction. Only if the competencies lists had positively affected supervisors' interactions with their students, could one expect increased student satisfaction. However, even improved supervisor/student interaction might not be a sufficient catalyst for increased student satisfaction. It is reasonable to believe that many factors combine to contribute to students' perceptions of satisfaction. Supervisee satisfaction is more likely to result from providing supervisees with information they do not already have; for example, more information about their practicum institutions, case loads, supervisors' expectations, and the supervisors themselves. As with the supervisors, it is noteworthy that supervisees in both groups tended to rate themselves as very satisfied with the clinical education experience.

Implications for Future Research

It is important to note that this was a pilot study, with most of the attendant limitations of exploratory work. It was a first attempt to focus on and quantify complex human perceptions, to impose experimental conditions on clinical situations that are difficult to control, to reduce the large number of resulting variables to meaningful parsimonious subsets, and to make sense of the resulting data on a rather small number of subjects. One aspect of this study that

deserves cautious interpretation was its application of factor analysis to data sets having 16 variables coming from as few as 13 subjects. Ideally, factor analysis would analyze data from about ten times as many subjects as there are variables. Although this pilot study applied a sophisticated and complex method of analysis to a comparatively small number of subjects, there were two worthwhile reasons to do so. The first was that only strong loadings were revealed on factors used for the subsequent comparative analyses along with characteristic values that were, without exception, very high. For example, the lowest factor loading for any variable used in this study was .794, which turned out to be Applied Academic Training for control group supervisors. Eigen values ranged from 1.639 to 6.74 and represented factors that combined to account for substantial amounts of variance in the 16 variables being analyzed. The lowest amount of explained variance in any solution was in a four-factor solution on the control group supervisors' data. The only two factors in that solution that were shared by the experimental group supervisors accounted for a disappointing 27% of the variance. The solutions on experimental group supervisor and supervisee data respectively accounted for 56% and 67% of the variance. The most convincing analysis was from a five-factor solution on the data from control group supervisees; three factors accounted for 71% of the variance. Although one would prefer to account for at least 60% of the variance in any solution, these results seemed respectable for the most part. The second worthwhile reason to share these findings was to demonstrate a viable method of analysis for future, larger N studies by other clinical education researchers and provide a basis for knowing what to expect. Even with its flaws, this pilot study provides valuable guidance to future researchers. It can serve as a trial balloon providing direction for follow-up studies that are better designed to reveal effective clinical education practices as they relate to information-sharing.

Implications for future research fall into three categories: list changes, questionnaire changes, and procedural changes. A modification that could be made to the CPC list is the addition of more personalized items, providing supervisors with more information. Changes also could be made to the questionnaire. For example, non-useful questionnaire items could be discarded and other items refined to create a tool that might better reflect the critical issues. Ideally, factors should not be reduced to single questionnaire items. When this happens, one must be skeptical about whether or not any single questionnaire item can adequately measure the construct it purportedly represents. Therefore, in subsequent investigations, it would be prudent to create additional questionnaire items designed to measure Applied Academic Training, Discussion and Summary, Supervisor Expectations, and Requests for Clarification. Stated another way, it might be worthwhile to re-think the purpose of the

questionnaire. Perhaps it should focus on something other than satisfaction, something made up of variables that could reasonably be more directly affected by a list of competencies. An example might be participants' perceptions of how well informed they are. Some procedural modifications that could be made in future investigations include: (a) providing the CPC list earlier, (b) suggesting potential applications and payoffs to both parties, thus "selling" the participants on the tools' potential value, (c) building in a procedure to verify that participants actually reviewed and discussed the list, (d) seeking other dependent variables, and (e) assessing satisfaction early, right after providing the CPC.

In conclusion, a list of students' clinical competencies provided to supervisors and students at the beginning of practicum did not alter grading variance nor satisfaction, as measured in this study. The lack of impact on grading variance may have been attributable to participants' imperfect application of the CPC, the independent variable tool. The lack of impact on grading variance also may have been attributable to inconsistent application of the W-PACC, the dependent variable tool, or to its inherently limited sensitivity. The lack of impact on satisfaction may have been attributable to insensitivity of the questionnaires, invalid assumption of causality, limited information regarding student competencies, and timing of the independent variable's introduction and/or measurement of the dependent variable.

If a competencies list does not affect satisfaction, it may have an impact on something else such as expectations. The absence of any significant differences between experimental and control groups within the context of this study does not necessarily mean that a list of clinical practicum competencies is without merit. If supervisors believe such information is helpful, then perhaps that alone justifies providing it. However, it is important to remember that only non-prejudicial information about students is appropriate for sharing. Anderson's (1981) findings seem to point to evaluative information as prejudicial. Those results should guide future researchers to carefully select and manipulate independent variables that will not bias supervisors' judgements of their students' abilities.

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Appendix A

CLINICAL PRACTICUM COMPETENCIES (CPC) LIST - LEVEL III

Characteristics of the supervisory conference with Level III students:

Discussion tends to focus on session analysis; for example, talking about events of therapy, client behavior, and materials. Some time is spent discussing the student clinician's interactions with the client. Most discussion and analysis is led by the supervisor.

Diagnostic Skills

A student at this level of training should be able to:

1. plan for client or responsible party interview with help from the supervisor;
2. administer the following diagnostic tests according to standardized criteria;
3. score tests accurately;
4. interpret test results from test scores;
5. generate appropriate recommendations with input from the supervisor;
6. select appropriate diagnostic tools with minimal help from the supervisor;
7. demonstrate knowledge of the components of an oral mechanism examination;
8. select, with the supervisor's guidance, pertinent information to include in reports;
9. demonstrate basic knowledge of the following procedure for collecting and analyzing language samples: _____

Treatment Skills

A student at this level of training should be able to:

1. establish, with the supervisor's assistance, appropriate long-term goals;
2. provide session goals (lesson plans) that adequately reflect long-term goals;
3. devise, with the supervisor's assistance, treatment procedures to carry out session goals;
4. give appropriate instructions to the client or be able to revise instructions following guidance from the supervisor;
5. carry out the following articulation approach: _____ ;
6. take data on structured, goal-related, client behavior;
7. interpret session directly from goal-related data;
8. provide, with the supervisor's assistance, alternative strategies for behavior management;
9. make relevant observations of the client's overall communicative competence.

Feedback/Evaluation

A student at this level of training should:

1. be able to interpret supervisory feedback with minimal guidance from the supervisor;
2. have a basic understanding of how the W-PACC is scored.

Appendix B

CLINICAL PRACTICUM COMPETENCIES (CPC) LIST - LEVEL IV

Characteristics of the supervisory conference with Level IV students:

Discussion tends to focus on self-analysis; for example, talking about the student's intervention strategies and their effects on client behavior and the ability to modify goals and materials within a session. Discussion topics and analysis are often initiated and led by the supervisee.

Diagnostic Skills

A student at this level of training should be able to:

1. independently plan and carry out client or responsible party interviews;
2. administer the following diagnostic tests according to standardized criteria: _____
_____;
3. score test results efficiently and accurately;
4. interpret test results in light of other available information (e.g., history, behavior, other tests, etc.);
5. generate appropriate recommendations with minimal supervisory assistance;
6. independently select appropriate diagnostic tools;
7. independently administer an oral mechanism examination;
8. independently select pertinent information to include in reports; and
9. independently collect and analyze a language sample using one recognized method: _____

Treatment Skills

A student at this level of training should be able to:

1. establish appropriate long term goals;
2. provide session goals (lesson plans) that adequately reflect long term goals;
3. devise treatment procedures to carry out session goals;
4. spontaneously alter treatment procedures as appropriate;
5. give appropriate instructions to the client;
6. spontaneously revise instructions to the client as appropriate;
7. interpret session directly from goal-related data;
8. collect and interpret data on pertinent client behaviors that relate only indirectly to treatment goals;
9. provide alternative strategies for behavior management;
10. independently assess the client's overall communicative needs; and
11. tailor a treatment program to meet the client's overall needs.

Feedback/Evaluation

A student at this level of training should:

1. be able to independently interpret supervisory feedback;
2. understand how the W-PACC is scored.

