The future of clinical education in speech and language therapy
Editorial

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Clinical placements are a crucial part of training for all allied health profession students, however sourcing sufficient high-quality placements is an increasing challenge and universities are responding by adopting alternative placements models to address the shortage (McAllister et al., 2010, Rodger et al., 2008). The shortfall in placement offers is an international issue and one that is on the current agenda of many allied health professions (Casares et al., 2003, Jones et al., 1998, McAllister et al., 2010). A number of factors have reduced placement capacity; new working practices, changes to service structures, staff shortages and financial constraints have all contributed to the decline in placement offers (Rodger et al., 2008, Hill et al., 2010). Despite this, the demand for supervised clinical placements still needs to be met and universities must comply with specific professional standards in terms of the amount and types of clinical experience provided.

What are the alternatives?

The stretch on clinical placements has led to the adoption of alternative models within the allied health professions. 'Non-traditional' placements such as project and role-emerging placements are used extensively on occupational therapy degree programmes (Prigg and MacKenzie, 2002, Thew et al., 2008), and are increasingly being used in speech and language therapy (Sheepway et al., 2011). Project placements involve students being allocated a specific project to work on by their placement educators, aiding their own professional skills development whilst fulfilling specific needs of the service. However, it can be challenging to ensure students are meeting their professional goals and some projects may result in less opportunity for skill development than traditional placements. Role-emerging placements involve students working collaboratively, with high levels of autonomy in a setting that has no existing service. Supervision is provided on-site by another discipline, whilst a speech and language therapist from the university provides remote supervision. Although evidence suggests that role-emerging placements promote confidence and independence (Thew et al., 2008), students may feel they lack support and guidance without a clinician on-site.

Simulation – a 'realistic' option?

Simulated learning environments are touted as one solution to increase capacity by supplementing more traditional education approaches. Though used extensively in medicine, nursing and some allied health professions (Bradley, 2006), simulation is a relatively new concept in speech and language therapy education, particularly in the UK. Simulation can take

a number of forms, the most common being ‘standardised patients’ portrayed by trained actors (Hill et al., 2010). Reported benefits include the provision of equitable and safe clinical experiences, improved inter-professional skills and stronger clinical reasoning skills resulting from on-line feedback from tutors (MacBean et al., 2013, Hill et al., 2010). Although evidence in support of simulation is growing, and this approach could reduce placement demand to some extent, there are a number of fundamental issues that have not yet been explicitly addressed in the literature. Working with standardised patients flies in the face of the ethos instilled into healthcare students that clients are complex individuals and that intervention approaches must reflect this fact. By ‘standardising’ patients, there is an inherent risk of losing both the complexity and individuality of real patients. Not only could this affect the range of student experience and their preparedness for the realities of the profession, but it is the individual variation amongst a real caseload that interests and motivates students to establish rapport and provide quality care. Considerable time and resources must be invested into training actors to portray these real-life complexities if this approach is to be adopted successfully. Simulations may hold some value in exposing students to adult ‘clients’, however many more speech and language therapists in the UK work with a paediatric population and simulation clearly holds limited value in this context. This issue warrants careful consideration in order to avoid a situation in which students undertake traditional paediatric placements but only experience working with adult clients in a simulated environment.

Conclusions

The answer may lie with adopting a different approach at each stage of student learning, tailoring the model to student’s level of knowledge, skills and confidence. Simulations may provide a safe, supportive learning environment for students to develop core skills prior to real clinical practice. The traditional model of one-to-one supervision in the mid-stages of training may still have merit, providing intensive supervision whilst fulfilling professional requirements for supervised sessions. Many final year students lack confidence in their own abilities (Brumfitt et al., 2005, Read, 2014), an issue that may be addressed by using role-emerging placements to foster autonomy prior to stepping out into the workplace. Introducing further simulation-based experiences at this stage may also aid skill development in more specialist areas of the profession where it has not been possible to secure placements for students.

The predominant model of one-to-one clinical supervision is becoming increasingly untenable, however further rigorous research is needed into the alternative models to ensure that standards

are met and that universities are able to continue providing a range of stimulating and supportive clinical experiences for students.

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