Education for practice : the development of competence in speech and language therapy students.

Jois Elizabeth Stansfield

EDUCATION FOR PRACTICE: THE DEVELOPMENT OF COMPETENCE IN SPEECH AND LANGUAGE THERAPY STUDENTS

by

Jois Elizabeth Stansfield

Thesis submitted for fulfilment of the Degree of Doctor of Education
School Of Education
University of Durham
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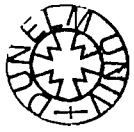

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Abstract

Education for competent practice in speech and language therapy is the focus of this thesis. Competence has many identities, from 'good enough' to 'excellent'. The literature on competence is reviewed and these identities are discussed in detail. They are then related to the speech and language therapy experience of education for practice, with attention being paid to the relationship between university and clinic-based learning.

An empirical study was undertaken to elicit the views of three groups involved in the clinical education of speech and language therapy students. These were students, clinicians supervising placements and academics who taught the students in university. All respondents reported the ability to recognise competent practice and demonstrated an understanding of the complexity of learning to become competent. Respondents focussed predominantly on the personal characteristics of speech and language therapists and the way in which these are used, together with knowledge and skills, in the service of professional work.

It is argued that personal characteristics, rather than the knowledge and skill aspects of clinical work are at the heart of competent practice. However, there is a complex and constantly changing relationship between these three aspects of competence, which is directly influenced by the context in which a therapist works. As a result, it is difficult to separate out or measure individual elements of competence in the clinical situation. What can be measured quickly and easily is not always what needs to be measured, and it will never be possible to measure every element of competent practice: there will always be a tacit dimension.

In order to enhance shared understandings about the nature of competence in the speech and language therapy student, therefore, communication between students, clinicians and academics is essential. The thesis concludes with recommendations on how this communication might be facilitated in the future.

Acknowledgements

This thesis has emerged as the result of support and encouragement from a large number of people over a long period.

Firstly, thanks go to my supervisor, Richard Smith, for his wisdom, guidance and good humour. He has introduced me to many new ways of thinking and enabled me to explore intriguing trails and detours while keeping sight of the main direction of the study.

Thanks are also due to the respondents in my study. They gave freely of their time, ideas and experience and the project could not have taken place without them.

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Embarking on a period of study at this level has been the result of family bequests. I owe a huge debt of gratitude to my grandmothers, one of whom first introduced me to in-depth philosophical discussion, while the other, through her example, demonstrated the value of practical knowledge. Also to my parents, without whose far-sightedness and commitment to education I would never have become a speech and language therapist in the first place.

Finally, and most importantly, I must thank Terry, Steven and Frances McAleer for keeping my feet on the ground, even when my head was in the clouds. This thesis is dedicated to them.

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Declaration

I confirm that no part of the material offered has previously been submitted by me for a degree in this or any other University. Material from the work of others has been acknowledged and quotations and paraphrases suitably indicated.

Statement of copyright

Chapter 1: Introduction

1.1 Background to the study

Speech and language therapists are professionals who work with individuals (of all ages and social backgrounds) who have communication disabilities. In the last century, the profession moved from being a disparate set of individuals who were self-taught, to an organised body of clinicians with a professional standing which is recognised in law. The education of speech and language therapy students is expected to enable them to develop capacities in areas which have become identified broadly as knowledge, skills and attitudes, in order, by graduation, to become competent practitioners in their chosen field.

Why do speech and language therapists (SLTs) need to be competent? There are answers at many levels. From a personal point of view, each SLT might be expected to wish do the best they can in the interests of their clients and themselves, leading to an enhanced sense of personal worth. Professionally SLTs have a duty to provide a level of care which is appropriate and sufficient to meet the communicative needs of clients. This is an ethical duty, which involves a responsibility to clients themselves, carers, professional colleagues and employers. Clients have a right to expect health care professionals to carry out their work in a way which takes account of the four main principles of health care: benificence, non-maleficence, justice and autonomy (Gillon, 1994). A competent therapist will balance these often competing principles in the interests of their clients, but incompetence can result in negative outcomes for clients, carers, colleagues and/or employers. At a regulatory level the professional body (the Royal College of Speech and Language therapists) has a duty to protect the reputation of its members and the statutory body (the Council for Professions Supplementary to Medicine, soon to become the Council for Health Professionals) has a duty to protect the public. Competent practice is essential if these duties are to be fulfilled and incompetent practice will be disciplined with the aim of assuring these outcomes.

Speech and language therapy (SLT) education takes place in the context of rapid change. Changes in medical knowledge and practice, for example, have led to a reduction in some clinical groups (such as cleft palate) while increasing others (such as dysphagia). Changes in social policy have effected moves from work in hospitals to community settings and from special to mainstream education. In addition there is increasing professional and educational regulation of courses. As a result, the concept of competence undergoes constant change. Over many years, the author has had frequent and extensive discussions with students and with SLTs working with students either as clinicians or academics. These have indicated that each group has its own approach to competence. Students aim to achieve a Licence to Practise as an SLT, clinicians are judging performance of students as future colleagues and academics are attempting to enable students to achieve an integration of academic and practical learning. As a result, it is likely that descriptions of competence and identification of elements of competence by the three groups will differ. In practice, at times there are difficulties in reaching agreement on the existence and nature of competence in individual cases.

This work has been grounded in a personal need to examine the theoretical underpinnings of education for practice in SLT, in particular in the field of practical education. Practical placements are the point at which SLT students are able to experience the work of the profession they aspire to enter, and are the key point at which three different groups within the profession come into contact, these being students, clinicians, and academics.

The questions addressed in this thesis are:

- to what extent can academic and practical learning lead to a student being judged competent;
- how can practical experience enable the development of clinical (professional) competence;
- how can SLTs achieve a consensus on the nature of competence in the newly graduating SLT?

1.2 Structure of the thesis

Education for competent practice is the focus of the thesis. The concept of competence is, however, disputed, with many identities, from 'good enough' to 'excellent'. These identities are discussed in detail, before being related directly to the SLT experience of education for practice. The literature on competence and work-based learning is reviewed in relation to speech and language therapy and an empirical study elicited the views of SLTs on the nature and development of clinical competence. The history and current status of SLT education are outlined in relation to the development of the graduating SLT clinician, with particular reference to the development of competence through practical education. Influences on current practice are identified and challenged and current philosophies on the education of SLT students are discussed.

A history of SLT education in the twentieth century sets the scene in chapter 2. This is followed in chapter 3 by an outline of theoretical approaches to identifying occupational and professional competence, and how some authors relate competence to expert practice. Chapter 4 discusses literature on competence in the field of SLT, while chapter 5 considers the identity of competence in higher education and how SLT curricula are designed to develop competence. Chapter 6 reviews the literature on work-based learning and how this relates to practical education for SLT students.

Chapters 7, 8 and 9 present the methodology and findings of an empirical study, which sought the views of SLT students, clinicians and academics on the nature of clinical competence and the ways in which this could best be developed. The final chapter, chapter 10, draws upon the literature and views of the SLT respondents to discuss competence in the context of the new SLT graduate, to identify good practice in practical education and to make recommendations for future action.

It is concluded that a clear vision of the competent SLT practitioner of the twenty first century is essential, and a shared language, frequently revisited is necessary to establish, maintain and enhance shared understandings about the nature of competent practice. Sound theoretical justifications for the future direction of practical education are needed to achieve that vision.

Chapter 2: Speech and language therapy education in the UK: a brief history

2.1 Introduction

Speech and language therapy in the U.K. at the beginning of the twenty first century is a small profession of just under eight thousand practising members. Speech and language therapy education of the millennium has its roots firmly embedded in the early years of the twentieth century. This chapter outlines the history of speech and language therapy[1] (SLT) education with particular emphasis on the development of the profession throughout the twentieth century. The impact of political decision-making and the ways in which professional and educational policies influence the education of SLT students as they seek to achieve professional competence is traced up to the present day.

2.2 Early history

Speech and language disorders have been documented for many thousands of years (van Thal, 1945) while McGovern (1994) traces modern speech and language therapy back to the eighteenth century. In the nineteenth century speech disorders aroused the interest of practitioners from diverse backgrounds. Hearing impairment attracted a great deal of interest from educationalists (McGovern, 1994). Neurologists began ground-breaking work in identifying the areas of the brain involved in speech production by studying the results of cerebrovascular accidents (CVA or stroke), while stuttering aroused the interest of surgeons as well as elocutionists (Hunt, 1857). In the main, however, these individuals did not collaborate to form a unified profession, rather being businesses in competition for trade (Rockey, 1980).

[1] Speech and language therapy has been the title of the profession since 1991. Prior to this, it was known as speech therapy. For the purposes of this thesis, the term speech and language therapy (SLT) is used interchangeably with speech therapy for events prior to 1991.

Speech therapists at this point trained themselves, using their background knowledge and experience as starting points. The formalisation of speech and language therapy education in the UK, however, can be traced back to the first decades of the twentieth century, when speech and language therapy began to become more embedded within institutions.

In the first three decades of the century, two groups of pioneers emerged. One group, elocutionists, or teachers of the art of speech, came from a theatrical or teaching background and for them formal training in remedial speech was offered by the Central School of Speech Training and Dramatic Art (Central School) by 1912 (Thurburn and Sargent, n.d.). The second group of pioneers allied themselves with the medical profession, working in hospitals within a medical model, rather than within an educational model. World War I decimated the male population and it is possible that the reasons for the progression, and female dominance, of the speech and language therapy profession are directly related to this fact. No written evidence has been located, but it is likely that many women who would have expected to marry and become involved in family pursuits had, instead, to direct their energies elsewhere. Certainly, the early pioneers were predominantly female and single (Armstrong and Stansfield, 1996). Speech therapy education developed rapidly after World War I. Central School established a separate Department of Speech Therapy in 1925, two hospital-based schools of speech therapy were established, also in London, in 1926 and 1932 and speech therapy education was commenced in Glasgow in 1928, becoming formalised as the Glasgow School of Speech Therapy by 1935.

By the 1930s 'graduates' from these courses appear to have held the first nationally, if not reciprocally, recognised qualifications in speech therapy in Britain (Robertson, Kersner and Davies, 1995). The main thrust of teaching, with varying degrees of emphasis, covered stuttering, voice disorders, childhood communication disorders, especially those resulting from cleft palate and neurological impairments (Eldridge, 1968). Normal voice production, anatomy,

physiology, neurology and some psychology with a psychoanalytical slant were also included in the syllabus (Armstrong and Stansfield, 1996).

In the 1930s two professional organisations were formed. One, the Association of Speech Therapists, represented the artistic, and the other, the British Society of Speech Therapists, represented the medical groups of speech therapists. For each group, competent practice was at the core of their professional identity, although Robertson et al. note that the two organisations were, for the majority of their existence, 'at daggers drawn' (1995: 10). Despite their differences and despite also the privations and complications of the second world war, these two bodies eventually agreed to amalgamate over the period of 1943-1945, with the College of Speech Therapists (CST) being established in 1945. CST was recognised by the government, through the Board of Medical Auxiliaries, as the body with responsibility for accrediting qualifying courses, setting national qualifying examinations, and approving entry to the professional register.

2.3 Post-war speech and language therapy education

After the establishment of CST, a number of new courses joined the original four. Two were established in the years immediately following the war and five in the 1960s as a result of the Robbins report (CHE, 1963). A further six opened in the 1970s predominantly as a result of the publication of the Quirk Report (DES, 1972), the only government publication ever to be solely devoted to speech and language therapy. This report recommended a major expansion of the service and increased student numbers. Two courses have since ceased to exist and one further course has opened, serving a perceived geographical need in the south west of England (CSLT Bulletin 1994).

Once CST was established, a syllabus was agreed and students were required to pass National Examinations in order to be accepted into the profession. All courses were of three years duration, including practical clinical sessions intended

to ensure practical competence. The nature of speech and language therapy education gave rise to a great deal of discussion over the years, with suggestions to reduce, as well as increase, the theoretical content of courses. van Thal (1956), despite herself being a very scholarly person, nevertheless considered a degree to be unnecessary and unlikely to be offered by universities, and there was considerable resistance within the profession to the establishment of the first degree at Newcastle University in 1964 (Harris, Court and Lessor 1989). There was a perception that degrees would be too academic and offer inadequate practical experience to develop competence. There was also a certain amount of professional jealousy. CST appeared to fear the loss of a monopoly in speech and language therapy education and there was also tangible disquiet over the relative levels of prestige of Diploma and Degree (CST Bulletin, 1962).

Table 2.1: SLT courses in the UK

Site	Institution	Course	Length
Birmingham	University of Central England	BSc (Hons)	3 years
Cardiff	University of Wales Institute Cardiff	BSc (Hons)	3 years
Edinburgh	Queen Margaret University College	BSc/BSc (Hons)	3/4 years
Glasgow	University of Strathclyde	BSc/BSc (Hons)	3/4 years
Leeds	Leeds Metropolitan University	BSc (Hons)	3 years
Leicester	De Montford University	BSc/BSc (Hons)	3.5 years
London	City University	BSc (Hons) PG Dip/ MSc	4 years 2 years/2.5 years
	University College London	BSc (Hons) MSc	4 years 2 years
Manchester	Manchester Metropolitan University	BSc (Hons) BSc Joint Hons (psychology and SLT)	3 years 4 years
	University of Manchester	BSc Hons	4 years
Newcastle	University of Newcastle	BSc Hons BSc Joint Hons (psychology and SLT) MSc	4 years 4 years 2 years
Plymouth	College of St Mark and St John	BA (Hons)	3 years
Reading	University of Reading	BA (Hons) MA	4 years 2 years
Sheffield	University of Sheffield	B Med Sci (Hons) M Med Sci	4 years 2 years
Ulster	University of Ulster at Jordanstown	BSc (Hons)	4 years

The Robbins report (CHE, 1963), however, demonstrated that these concerns were common to many professional groups and its arguments clearly impressed CST Council members (CST Bulletin,1964). By 1967 Council had recommended that all courses should proceed to degree level education. Speech and language therapy qualifying courses have continued to develop and at the time of writing there are 21 courses, sited in 15 institutions around the UK, as shown in Table 2.1 (RCSLT, 2001). One new course has recently been proposed in Norwich and there is a further course in Trinity College, Dublin, which shares many of the characteristics of the UK courses.

2.4 The political context

In the early years of CST, speech and language therapists were registered as medical auxiliaries (CST Bulletin, 1952), but this was increasingly viewed as being inappropriate. As a result, despite strong government pressure, CST declined to join the Council for Professions Supplementary to Medicine in 1960, and later also remained outside the educational provisions of the 1989 National Health Service and Community Care (NHSCC) Act (Robertson et al., 1995).

Philosophical and practical considerations were factors in both of these decisions. Speech and language therapists work with children and adults across a range of service environments, which encompass educational, social work and voluntary agencies, as well as the National Health Service. Thus, their work is not easily identified as being so 'medically' related as the majority of professions which fell under the provisions of the CPSM Act. Professional autonomy was guarded zealously. CST had a government mandate through Statutory Instruments, to oversee speech and language therapy education and licensing, which it was unwilling to lose. In a cogent argument against joining CPSM (Editorial, 1960) Renfrew identified the key issue as speech and language therapy autonomy from the medical profession.

In both CPSM and NHSCC Acts, responsibility for control over pre-qualifying curricula have also been at issue. In the early days, CPSM dictated the pre-qualifying curriculum for professions within its embrace and still has a very strong influence. The NHSCC Act resulted in a transfer of funding for occupational therapy, physiotherapy and some other health care students from education to health care budgets, with implications for an increase in the power-base of employers, rather than the profession or higher education institutions (HEIs).

In the wake of the 1997 change of government, the Dearing report (NCIHE, 1997) recommended a major change in funding for higher education and the government ratified the decision to charge students for a proportion of their fees and reduced other levels of student support in line with the policy of the previous administration. A rapid unilateral political decision was made to transfer funding from education to health budgets, for almost all health care students, including SLTs (CREST, 1997). This may be seen as a principled approach to supporting individuals whose degrees do not lead to highly paid posts, a political unwillingness to address the low salary levels of NHS staff, or a cynical move to impose much greater control on health care education and training. What is clear is that speech and language therapy is now effectively covered by the educational contracting provisions of the NHSCC Act 1989 which it had, up to that date, fought successfully to avoid.

In the late 1990s, the profession, together with a number of other small bodies, was lobbied hard to reconsider joining CPSM before that Act was repealed and replaced by a Council for Health Professions (CHP) Act, due to be enacted by 1998 (NHSE, 2001). CPSM had appeared to become less restrictive over the years, and this, together with assurances over increased statutory protection for the profession proved seductive enough for RCSLT members to agree to join the CPSM in 1998. The CHP Act will be in place by April 2002: at that point, professional regulation will become the statutory duty of CHP.

2.5 Professional accreditation of courses

The move to CPSM will mean changes to accreditation of courses in the future, but at the time of writing (2001), RCSLT and CPSM share responsibility for this accreditation. RCSLT has been active since its inception as the CST in 1945, in 'determining and establishing a national policy in the education of speech and language therapists' (RCSLT, 1996a: 232). It sets baseline criteria for course length and clinical experience, with the stated aim of enabling students to graduate as competent SLT clinicians. As students completing accredited courses are eligible for a Licence to Practise and, from 2001, State Registration, the accreditation process is intended to be comprehensive and rigorous. The outline in the professional guidelines, Communicating Quality 2 (CQ2) (RCSLT, 1996a), is supplemented by detailed guidelines which are revised and issued by the Academic Board of RCSLT on a regular basis.

Many course innovations have been the result of reflection upon, and identification of, best educational practice, but others may have emerged as a result of institutional pressures for high-value, low-cost course provision. It appears that at times the Academic Board of RCSLT, by prescribing unpopular restrictions on the structure of SLT degree courses, has acted to protect the public from inadequately clinically qualified (incompetent) graduates and to protect the profession, students and the speech and language therapy educators from the institutional pressures put upon them. Thus, the innovation of a three year Honours degree in Leeds led to the specification that such courses must average at least 35 weeks a year; development of Masters courses led to the requirement for these courses to have two extended academic years of study (80 weeks), mainly to ensure that students could study academic content in sufficient breadth and depth and still be able to complete the necessary clinical placement hours identified by RCSLT as the minimum deemed to be necessary to achieve competence (RCSLT, 2000).

The accreditation process itself maintains a strong similarity to other professional accreditations (Burrage, 1994). It consists of peer review, and accreditations are frequently 'conjoint' with institutional validation of Degrees. It involves the production of a critical review of the course, with an outline of strengths, weaknesses and action which has been taken to rectify problems; external examiners reports; a full course document with details of any modifications for the current accreditation; assessments; clinical placements and other practical experience; and CVs of staff associated with the course. Additional documentary evidence of student intake, progression, output statistics and employability of graduates is required.

The accreditation process is considerably less confrontational than in the past, when panels appeared intent on finding fault rather than facilitating success. The visiting team normally includes one or two speech and language therapists, plus two individuals from associated disciplines. The course team is required to defend changes from the previously accredited course, identify where core content is taught and justify approaches to learning, teaching and assessment. Accreditors also expect to meet speech and language therapy managers, clinicians and students, without the course team present, in order to establish if their experience supports the assertions of the course team. As SLT courses recruit on the basis of offering a route to professional competence and entry to a professional register, accreditation is essential for the continued existence of a course. What is at stake is the ability of a course team to deliver a course which is professionally acceptable.

2.6 The requirements of higher education

The education of SLT students proceeds in the context of rapid change within higher education (HE). The Dearing Report (NCIHE, 1997: 7-8) lists succinctly the demands upon HE.

... UK higher education must:

- encourage and enable all students, whether they demonstrate the highest intellectual potential or whether they have struggled to reach the threshold of higher education – to achieve beyond their expectations;
- safeguard the rigour of its awards, ensuring that UK qualifications meet the needs of UK students and have standing throughout the world;
- be at the leading edge of world practice in effective learning and teaching;
- undertake research that matches the best in the world, and make its benefits available to the nation;
- ensure that its support for regional and local communities is at least comparable to that provided by higher education and its competitor nations;
- sustain a culture which demands disciplined thinking, encourages curiosity, challenges existing ideas and generates new ones;
- be part of the conscience of a democratic society, founded on respect for the rights of the individual and the responsibility of the individual to society as a whole;
- be explicit and clear in how it goes about its business, be acceptable to students and to society and to seek continuously to improve its own performance.

Some of the ways in which these demands impact upon SLT students are discussed below.

2.6.1 Student numbers

An expansion in student numbers across HE, first recommended in the 1960s by the Robbins Report (CHE, 1963), has been mirrored by a gradual increase in SLT student numbers over the years to an intake of around 600 in 2000 (Pigram, RCSLT, personal communication). There is a current imperative from the government for a further rapid increase in SLT numbers in England and a more modest increase in Northern Ireland, Scotland and Wales (CREST, 2001). Expanding access to allow students with non-traditional backgrounds and qualifications to enter HE is seen in the light of the ethical principles of equity and justice for the student (Bottery, 1992). It is also important for vocational courses for a profession to reflect the population with which it works (Eastwood, 1995), thus

increasing the competence of the profession as a whole. In the context of SLT, non-traditional students include almost any group which is not white, middle class and female. The profession has a healthy intake of mature students, but has never successfully recruited many students from ethnic minorities (Stapleford and Todd, 1998) or male students (Boyd and Hewlett, 2001).

Expansion of numbers of self- funded students has also become a matter of financial survival for institutions. The attempt to recruit more students from the lucrative overseas market is an overt example of financial decision-making within institutions (e.g. QMUC, 2001). Here, RCSLT has taken a view, directing that overseas students whose mother tongue is not English must demonstrate a high and measurable level of spoken and written English (RCSLT, 2000) to be accepted onto a course. This ensures that students have a good chance of succeeding academically and achieving clinical competence when working with the English speaking population, although a tension can be seen between this requirement and the inability of the profession as a whole to work in the many other languages spoken in the UK.

2.6.2 Course structure

Many HEIs and most SLT courses work to a two semester, modular degree system. Modularity was developed in order to offer flexible patterns of student learning and easily recognised and accredited academic achievement. This could then be traded through a Credit Accumulation and Transfer (CAT) scheme, to allow students to plan their own route towards a degree. To date, SLT courses have found it difficult to facilitate this flexibility of approach. There appear to be four main reasons for this. Firstly, the vocational nature of the degrees means that there is a need to produce graduates qualified for the profession they are to enter and therefore course content is constrained. Secondly, professional accreditation requires a course to demonstrate 'a fully integrated whole, where academic theory and practice are intimately blended' (RCSLT, 2000: 3). Thirdly, individual courses

order their content according to their own philosophical approach. Fourthly, semesterisation and modularity were often imposed, rather than introduced after consultation and agreement, so academic ownership of the process is limited. As a result, transfer, even between SLT courses, is rarely possible during an academic year, or beyond the end of year one.

2.6.3 Education for the workforce

Change in HE also occurs in the context of concern over the level of skills in the entire workforce in the UK. Education and training for work has a much broader base than just the provision offered by HE, but mass participation in HE, the stated aim for Britain in the twenty first century (NCIHE, 1997), is closely related to increasing the skills needed for the future workforce.

At a general level, HEQC (1997a: 13) argues for 'key skills needed in employment' (communication; application of number; information technology; managing one's own learning; working with others; problem solving) to be identifiable learning outcomes of all degrees. HEQC (1997b: 88) also suggests that 'the possession of general employment related skills' including ' an understanding of the constraints under which employers operate' should be common to all undergraduate programmes. There is also strong pressure on HEIs to include work experience as an element of every degree, regardless of its nature (NCWE, 1999). In a way, this move to the vocationalisation of HE works in favour of SLT students, who have always been expected to be prepared explicitly for the profession they are to enter. The emphasis on skills development in many publications does, however, suggest a somewhat instrumental approach to the required output from HE.

2.6.4 Research

Evidence-based practice is a goal of competent professional work and research is integral to HE as a part of developing the evidence needed for practice. Well

before SLT courses were included within HEIs, the profession established its own research base, as well as relying upon the work of related disciplines such as linguistics, psychology and medicine. As early as 1938, the vast majority of papers in the profession's journal were original articles and in the first ten years of its existence, over half were authored or co-authored by SLTs (Armstrong and Stansfield, 1996). The current journal (the International Journal of Language and Communication Disorders) publishes peer-reviewed papers, the vast majority authored by SLTs, to an international readership. SLTs with research and some with clinical posts also produce books, assessment materials and publish in a wide range of other refereed journals, while most SLT academics are expected to be involved in research as part of their contract of employment. All of this activity is considered by the professional body to contribute to the development of competence in pre-qualifying students (RCSLT, 2000), enabling them to question and critically evaluate current practice and develop their own skills in clinical evaluation and research.

2.7 Conclusion

SLT education has grown from small beginnings to a formal academic and professional qualification. There are many competing priorities for the education of the SLT student today. The academic quality of all HEIs is regulated by the state, through Funding Councils and the QAA, and through internal quality assurance processes of the individual HEIs. There has been a decreasing 'unit of resource', or funding, for each student for the past twenty years which has led to a drive to find additional finance. This has involved increasing student numbers (not just in the interests of equality of opportunity), recruiting overseas students who pay high fees and encouraging staff to seek research funding, rather than merely pursuing scholarly activity or un-funded research.

The NHS, through the National Health Service Executive (NHSE) and in England through local funding consortia, exerts additional influences on health care

courses, with a clear agenda of education specifically for the work-place. Over and above this, the SLT profession and professional education is regulated through CPSM/ CHP and by the professional body, RCSLT, which continues to judge courses on their ability to educate SLT students to become competent practitioners in their profession.

The available knowledge base, as in almost every field of study, is increasing exponentially and HEIs are expected to be in the vanguard of current knowledge in course delivery.

SLT has been at the forefront of many of the changes now being experienced by HE. The profession has, since its inception, demonstrated an awareness of the need to reconcile theory and practice; discipline knowledge and its application in a practical environment. The vocational nature of SLT courses and the accreditation they have experienced are now a part of the entire HE system. Speech and language therapy therefore, lives in interesting times.

Chapter 3: Approaches to identifying occupational and professional competence

3.1 Introduction

The development of competence is predominantly seen to commence at university level for a wide variety of professions including SLT. Competence is, however, a concept that has been described as having:

> no agreed definition....a word with a wealth of meanings...which attracts many different shades of interpretation. (Lum 1999: 404)

There are many approaches to the concept of competence, ranging from behaviourist approaches which judge performance on individual tasks, through concepts of generic competences, where competence equates with a capacity or disposition and on to the consideration of competence within a developmental process in the growth from novice to proficiency. This chapter presents differing philosophical approaches to the identification of occupational and professional competence. It evaluates differing approaches to the definition of competence and considers these in relation to expert performance, in order to contextualise the aims of professional pre-qualifying education. The chapter concludes by reiterating the problems of reaching a consensus on the nature and development of professional competence.

3.2 Describing competence

The concept of competence is at the heart of all professional practice. The definition of professional competence, however, varies according to the philosophical approach of the writer. In the 1930s professional competence was regarded as being synonymous with 'properly qualified' (Eraut 1994), for most groups including SLT. Now 'competence' can encompass widely varying

concepts, from 'good enough' to 'very able'. The word can refer to aspects of performance on a single task, to the overall demeanour of an individual; from 'ready to start work' to reliable and proficient (Eraut, 1994). A fundamental issue in defining competence is that the word is used to represent significantly differing philosophies. At one end of the spectrum, competence is seen on a binary scale: a person either is, or is not, competent, based on published criteria. Here competence is an outcome and fits into an operational definition. The scope of this competence is defined in a given range of tasks, roles, or situations and the competence is an 'all or nothing' concept. This is exemplified in the work of National Council for Vocational Qualifications (NCVQ).

At the opposite end of the scale are approaches with their roots in concepts of expert practice and educational and philosophical thinking. Here, competence is viewed as falling part way along a continuum on the road from novice to expert practice. Judgements of competence within this framework involve qualitative as well as quantitative aspects. They address the context in which professional action takes place, consider capability (identification of potential) as well as evidence of current performance and usually include consideration of the mental processes involved in using knowledge in decision-making. Here the work of Schon and the Dreyfus brothers is influential. Their approaches are complex, do not lend themselves easily to simplification and therefore are not amenable to producing absolute measurable outcomes.

In neither of these approaches are concepts of competence value-free. Jessup (1991) and his colleagues use evangelistic language to promote the NCVQ agenda, while the 'continuum' proponents often appear to be hiding behind concepts of tacit knowledge (Polanyi, 1958), which remains secret from those uninitiated into the mysterious (and closed) world of a profession.

Between these poles are Gonczi's (1994) description of Australian approaches to identifying competence and the attribute-based management school approach to competence exemplified by the McBer organisation (Spencer and Spencer, 1993). Each of these approaches is outlined below and discussed in terms of professional competence.

3.3 An outcomes based view of competence: National Vocational Qualifications

3.3.1 The NVQ approach

National (and Scottish) Vocational Qualifications (NVQs) were introduced into the UK as an attempt to provide a coherent single entity for vocational qualifications, rather than the patchwork approach Jessup (1991) suggested was on offer up to the mid 1980s. The National Council for Vocational Qualifications (NCVQ) was set up in 1986 to address the issue of occupational competence. Jessup was a prime mover in the instigation of this organisation and he provided the first coherent outline of the philosophy, provenance and practical development of NVQs (Jessup, 1991).

NVQs were designed as an overarching scheme, which claimed to give the learners power over their own development. There was to be an outcomes-based assessment system, whereby individuals became qualified on demonstrable skill (evidence) within a working environment. Skills development was to be separated from any particular learning experience (curriculum or training requirement) and from underpinning knowledge. Demonstration of skill implied the existence of underpinning knowledge. Each element of occupational activity was to be identified, the context and level of performance defined and assessed and once all elements had been completed successfully, the NVQ candidate would be certificated as competent. Jessup echoed the political culture of the time in

attacking professions' power and strength. In his view, 'The specification of outcomes provides the key to unlocking the education and training system' (1991: 11). In other words the exclusivity and mystery of different occupations and professions would be stripped away and competence would become a transparent concept.

NVQs are assigned at levels from 1 to 5 and have notional correspondence to educational qualifications (see Table 3.1).

Table 3.1: Notional correspondence of qualifications

Higher degree	N/SVQ 5
Degrees	N/SVQ 4
A level/AS level/Scottish Higher	N/SVQ 3
	N/SVQ 2
GCSE/ Standard Grade	N/SVQ 1

The qualifications system was extended with the development of General National/Scottish Vocational Qualifications (school, or college, rather than work-based) in 1993, although these were later subsumed within the new A level (2000) and Scottish Higher Still (1999) curricula. Organisations under the NVQ umbrella have changed their names and remits but the general thrust of the movement remains true to Jessup's vision.

3.3.2 Practical issues in the NVQ model

Many authors (e.g. Gonczi, 1994; Hyland, 1994; Pring, 1995; Winter, 1995; Mansfield and Mitchell, 1996; Lum, 1999) have criticised the NVQ system, some in measured terms and others in language as robust as that of Jessup and his colleagues. There are three major criticisms of the NVQ system in relation to professional competence. Firstly, it is asserted that the focus on outcomes

disregards the process of learning; secondly it is atomistic not holistic; and thirdly, knowledge is not addressed in a satisfactory manner. A fourth critisism is of the evangelistic tone of much of its literature.

3.3.2.1 Outcomes, not process: In the NVQ model, education and training must be defined by outcomes which are definable and predictable. Learning is separated from a traditional syllabus or curriculum delivery. The implication is that the outcomes model is not concerned with the process of learning. The model requires an individual personal baseline assessment, or 'profile of competence', guidance for the worker to discover learning opportunities, individual action plans, programmes of learning, as well as continual assessment, unit credits and a completion of the action plan. All this assumes an individual willing and interested in his/her own vocational development. Personal motivation is another assumed 'given' in this model, as there is a very high burden of responsibility placed upon the individual learner. Burke (1995), in support of the NVQ model, asserts that lack of curricular prescription and alternative modes of learning are highly desirable, but he fails to engage with the underlying point of principle, that the learning process itself is part and parcel of the development of competence.

3.3.2.2 Atomistic, not holistic: In the NVQ model elements of competence are required to be assessed separately, but the system does not allow for an assessment of the overall performance or capability of a candidate. Jessup gives a strong critique of assessment procedures in education, as he perceives them. He criticises sampling, believing that comprehensive assessment of each current aspect of learning should take place. The implication, although not the explicitly stated view of Jessup, is that the whole, in NVQ terms, is precisely the sum of its parts, although to many educationalists, the whole is greater than the sum.

3.3.2.3 Knowledge: The place of knowledge in the NVQ definition of competence has also given rise to a great deal of comment and is of particular

relevance in the consideration of learning at higher levels. Jessup was clear that skill could not exist without (unassessed) underpinning knowledge and understanding required to achieve competent performance. Knowledge itself, however, was not to be assessed directly: the existence of skill was deemed to prove the existence of knowledge and understanding. The value of higher education is acknowledged by Jessup so far as professional competence is concerned, but only in order to provide the underpinning knowledge required to conform with his model and demonstrate skilled action in NVQs at level 5 (the highest level). Jessup stated that his brief was not to evaluate the merits of higher education objectives, but he clearly had a low opinion of educational assessment in HE 'higher education ..... woolly concepts' (1991: 131) and he believed that by adopting the NVQ model HE would be helped to clarify its objectives. Thus he sees education very much as the servant of operational competence, rather than as having any intrinsic value.

3.3.2.4 Evangelism: Many authors in favour of NVQs present a stance which brooks no disagreement. As indicated by Ecclestone (1997), if others do not accept the case for NVQs, then they are dismissed as uninformed, misguided or simply obstructive and wrong. Even where concerns are taken at their face value by Jessup and his colleagues (e.g. Burke, 1995), they are dismissed without accepting the full complexity of an argument, or by redefining aspects of that argument in a way unintended by the original author.

Politicians tend to look for simple answers. The development of NVQs seems eminently suited to this, apparently providing clarity, in form and substance, and allowing competence to be demonstrable and its identification transparent. The extent of the success of NVQs provides evidence that it has met a need or 'social resonance' (Barnett 1994: 157).

3.4 Professional competence as capacity

3.4.1 The Australian approach

At around the same time as Jessup was producing the NVQ framework in the UK, work was also taking place in Australia to develop 'competency based standards' for professional work (Gonczi, Hager and Oliver,1990). Gonczi et al. define a competent professional as one who has 'attributes necessary for job performance to the appropriate standards' (1990: 9). In their terms, attributes encompass knowledge, abilities, skills and attitudes 'often referred to as competencies' (1990: 9), however these do not in themselves produce competence, as competence is dependent upon performance of a (working) role or set of tasks. Gonczi (1994) makes a biting critique of the NVQ approach as a model for professional competence. It is, he states:

> positivist, reductionist, ignores underlying attributes, ignores group processes and their effect upon performance, is conservative, atheoretical, ignores the complexity of performance in the real world and ignores the professional judgement in intelligent performance. (Gonczi, 1994: 29-30)

And he suggests that the model is inappropriate for judging professional competence. The approach to identifying competence adopted in Australia, which Gonczi describes, while itself part of the development of occupational standards, is relational:

> a complex structuring of attributes needed for intelligent performance in specific situations.... incorporates the idea of professional judgement. (1994: 29)

Here, competence appears to be comparable with the 'capability' concept presented by Stephenson and Weil (1992) in the UK. Higher Education for Capability was an educational initiative sponsored by the Royal Society for Arts (RSA) and developed in parallel with NVQs in an attempt to co-ordinate the

educational aspects of HE with an outcome of employability for graduates. Stephenson and Weil (1992: 1), however, state from the start that:

> capability does not easily lend itself to detailed definition. It is easier to recognise it than to measure it with any precision.

Gonczi's outline of the competent practitioner is one who has the capacity to use a complex interaction of knowledge, attitudes, values and skills in a range of contexts. In teaching, for example, the knowledge base would need to mesh with ethical standards and the ability to communicate with children. The fundamental thrust of the Australian initiative was to change styles of learning away from didactic lectures towards negotiated programmes of learning, applied knowledge and skills and collaborative learning (Hager,1996), but unlike the NVQ approach, the Australian model resists reducing descriptions of ability to 'ever more separately measurable competences' (Gonczi, 1994: 27).

3.4.2 Competence and capability

In Australia, professions have typically developed between 20-40 elements of competence. Performance criteria are standards described not as long checklists but in prose designed to ensure the holistic nature of competence is understood. Gonczi (1994) states categorically that competence cannot itself be observed directly. It can only be inferred from performance. At first sight this appears to follow Jessup's direction. However, Gonczi, in taking the concept of competence as 'capacity' emphasises that the judgements of competence must incorporate the 'holistic integrated performances' (1994: 35) in the person's work. The sub-plot is one of integration of skills and knowledge with an ability to utilise these appropriately in context: an 'holistic nature of capability, the essential integration of personal qualities, skills and specialist knowledge which enables students to be effective.' (1994: 3).

Capacity is a central characteristic of Gonczi's definition of competence. He argues that, despite having a superficial similarity to the NVQ approach, there are significant differences between the UK and Australian models. Poor performance in one area of competence can be compensated by strengths elsewhere. This will rely on professional judgement, thus being less transparent, less simple (or simplistic) than would be wished by proponents of the NVQ system. Gonczi suggested, however, that validity is high and reliability can be addressed through training and moderation programmes. Hager and Gonczi (1993) argue that the conception of competence they present is richer and more holistic that alternative approaches. They suggest that 'fragmenting of an occupation into a myriad of tasks' (1993; 41) is unhelpful in identifying competence, as actual practice synthesises an overall approach to tasks. They do not, however, advocate 'holism' if this then rules out all analysis. Rather, they consider holism in terms of performance on complex tasks, which are inter-dependent rather than discrete and which involve situational understanding.

The complexity of this approach occurs at the level of the professions devising the statements of competence, encompassing not just skills but knowledge, values and attitudes, in the performance of a working role. Therefore there is greater ownership of the process, subsequent greater validity and a recognition of the complexity of judging competent performance. The statements are still, however, the standard upon which a practitioner is judged.

There is little discussion of this model in the British literature, but it appears to avoid the disadvantages of the NVQ approach (Hager and Hyland, forthcoming). It takes account of the nature of professional practice and professions appear to accept the model because they have been involved in its development. It is, however, still concerned with practical rather than intellectual competence, and while it takes cogniscence of attitudes and values, these appear to be firmly

grounded in professional practice, rather than the broader stance of the individual learner.

3.5 An attributes view of professional competence

3.5.1 The competency causal flow model

A number of business schools in the United States have approached the development and definition of competence from a quite different angle from those outlined above. McBer and his colleagues (e.g. Spencer and Spencer, 1993) modelled a system of identifying competence derived from observing expert practitioners, which takes account predominantly of personal attributes rather than on-task performance. Spencer and Spencer (1993: 9) talk of 'competency' but define a competency as:

> an underlying characteristic of an individual which is causally related to the criterion-referenced performance in a variety of situations.

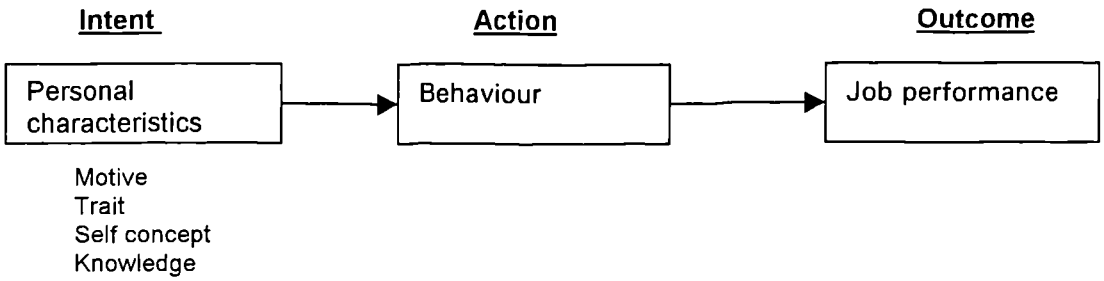
This underlying characteristic is 'a deep and enduring part of the person's personality' (1993: 9) which will predict behaviour in a variety of structures.

The underlying characteristics or competencies Spencer and Spencer specify are the person's motives, traits, self-concept, knowledge and skill. In their definition, motives, traits and self-concept 'competencies' produce skill, and skill predicts outcomes. The competencies are, however, deeply buried and being central to the personality they are far more difficult to develop or measure than knowledge or skills.

The Spencer and Spencer terminology has a number of differences of perspective from the competency models of the UK or Australia. The 'competency' predicts the outcome, rather than being the outcome, and there is a flow from intention to

action to outcome, which is demonstrated in a 'competency causal flow model' (see Figure 3.1)

Figure 3.1: Competency causal flow model



Spencer and Spencer, 1993

Another difference from the previous approaches is that criterion-referenced outcomes are recognised as needing to take account of the intensity and completeness of the action, the size of the impact, complexity of the task, amount of effort required and the unique dimensions within the situation. They require qualification, they are not all-or-nothing judgements and thus competencies are seen to have more than one dimension.

3.5.2 Practical issues in the competency causal flow model

3.5.2.1 Competencies dictionary: The MacBer organisation went on to produce a 'competencies dictionary' to assist in identifying generic competencies. Competencies are grouped (clustered) on the basis of the relationship between social routine and surface behaviour. Criteria for rating are then scaled, with varying ratings depending upon the scale concerned. For example, within the 'helping and human services' cluster of competencies, 'listening and responding to others' has a scale from –1 to +5. Finally, competencies are divided into two categories, threshold and differentiating. Threshold competencies are essential characteristics, which are needed by everyone in a particular job to be minimally

effective. Differentiating competencies are asserted to distinguish superior from average performances.

Ratings for different groups of workers are identified as attributes which would be deemed as producing superior performance in one field may be counter-productive in another. Spencer and Spencer (1993) suggest, for instance, that in helping and human service jobs, superior 'carers' are likely to have a profile of moderate achievement, high affiliation and moderate power motive, while superior 'influence helpers' such as teachers or social workers will have low-moderate achievement, high affiliation and high power motives.

3.5.2.2 Fitness for purpose of the model: Some notes of caution are needed in considering this approach. The entire system is culturally embedded in the US and specifically, has been devised in business schools. Much of the work appears to assume that there is one particular type of 'good' worker in any given field, with some dated stereotypes in the clusters of traits assumed to be necessary, at least for the fields of education and health care. To an extent, the argument appears not one of training but of recruiting the right people in the first place, begging the question: is the competent worker born or made? If traits are taken to be central, those which are proposed to be typical of expert performers appear largely to be within a masculine frame of behaviour, a fact acknowledged in later work by the same research group (Case and Thompson, 1995).

Another criticism, based on empirical data, is that use of these models in training does not appear to improve managers' competence rating greatly. For example using the criterion referenced competency scales in work with doctors had little impact in improving the quality of care (Spencer and Spencer, 1993), and even in management training there was only limited success in improving performance through training (Eraut, 1995). The scales are therefore perhaps not measuring what they claim to measure.

This approach to identifying competence does, however, have strong face validity, appearing to take account of complexity and variability and including the person and situation in the process of measuring competence. No doubt as a result, a huge industry has grown up, using these approaches in widely diverse fields for recruitment, promotion and training of the workforce. The detail is comforting. It seems, however, that the McBer school of which Spencer and Spencer were members has predominantly achieved a marketing success, which has still to be proven outside of management and business contexts.

3.6 Process views of professional competence: cognitive approaches

3.6.1 Competence and subconscious knowledge

The cognitive tradition is discussed in the writings of philosophers such as Polanyi who explores concepts of knowledge and understanding, and linguists, notably Chomsky, who theorises about human language acquisition, structure and function. Polanyi (1958; 1967) discusses in detail his philosophy that we know more than we can say. His work explores the concepts of tacit knowledge. This is the human ability to recognise, understand and respond to features of a situation without being aware of this ability. Polanyi believes that all human knowledge has a tacit dimension which it is not possible to bring to the level of conscious functioning, but which nevertheless underpins much of an individual's conscious action and thought. Chomsky (1957; 1966) defines language 'competence' in a similar way, as an idealised cognitive representational system of rules which any speaker knows subconsciously. Chomsky contrasts this with 'performance', which is the actual use of language. In a series of closely argued publications, he suggests that linguistic competence relies on an innate 'language acquisition device' which enables humans to acquire language skills and transform deep language structures to surface syntactic performance. Embedded in each of these

theories is a concept of intuitive knowledge: the ability to know, without being aware of the knowledge and to act because of this deep seated knowledge.

Eraut (1994) suggests that professional practice described as intuitive is, in fact, essentially a deep-seated cognitive activity. A professional encountering a novel situation will generate hypotheses, map information onto previous experience, explore possible and actual causes of action, without necessarily being able to explain how or why this thinking and action took place. Barnett (1994) adopts this approach in his discussion of competence in higher education. He suggests that in academic (and particularly in professional) life, action is saturated with thought and understanding. Some knowledge and understanding will be tacit and not amenable to examination. He argues that understanding is a mental state, which can exist without being apparent to an external observer, but educators need to devise methods which enable students to show their understanding through their words or actions and to use their performance in order to demonstrate competence.

3.6.2 Competence and reflective practice

In relation to developing professional competence, Schon (1991; 1993) addresses ideas which are explored by Polanyi (1958; 1967). In particular Schon asserts that competent professional practitioners 'exhibit a kind of knowing-in-practice which is tacit' (1991: viii) and demonstrate an ability to reflect on intuitive knowledge during their practical actions. Schon contends that an instrumental 'technical-rationalist' means-end approach to learning is inadequate as an approach to develop competence. He suggests that technical rationality, with its emphasis on problem-solving, is unable to encompass the need for problem setting experienced by many professionals.

Schon states that:

> In the varied topography of professional practice, there is the hard, high ground where practitioners can make effective use of research based theory and technique and there is a swampy lowland where situations are confusing 'messes' incapable of technical solution. The difficulty is that the problems of the high ground, however great their technical interest, are often relatively unimportant to clients or to the larger society, while in the swamp are the problems of greatest human concern. (1991: 42)

The setting (or framing) of a problem requires order to be imposed on a problematic situation. Schon describes a model of professional practice incorporating artistic and intuitive aspects of behaviour. He suggests that all competent practitioners depend upon tacit 'knowing-in-action' (1991: 49) which they utilise in their daily working life. They are able to recognise phenomena and patterns and identify aspects of a situation which make it unique. Similarly professionals display skills and make judgements which do not have clearly articulated criteria and for which they cannot state the rules and procedures.

Schon suggests that 'knowing-in-action' is an inherent part of intelligent behaviour, which develops in professional education through reflection, so that the individual thinks about what they are doing and makes changes in order to become increasingly competent in their chosen professional field.

Schon proposes a model of professional practice which incorporates what he calls 'professional artistry' (1991: 268) and on-line decision-making during professional work. Professional artistry includes the largely tacit framing of situations in order to create a definable (even if ill-defined) problem to be addressed. Through knowledge-in-action, the person's behaviour demonstrates their understanding. Reflection-in-action occurs during a particular professional activity when decisions may be made on a moment-to-moment or longer-term basis depending upon the way in which all elements of a situation are perceived and how they are changing. Finally, there is reflection-on-action which may take place after the event and

allow a more leisurely evaluation of what helped and what hindered the progress of the professional situation.

Schon's approach to competent practice is radically different from the NVQ approach, the Australian approach or the attributes approach to competence. He does not atomise the elements of practice. He presents a model which encompasses the unconscious and conscious aspects of behaviour and he describes his understanding of the ways in which practitioners deepen their knowledge, by moving from a mismatch between theoretical and practical knowledge to the ability to 'reflect-in-action' as an experienced practitioner.

There are a number of critiques of Schon's work, of which the most complete is that by Eraut (1994). Eraut suggests that Schon's theory has a number of defensible elements. He agrees that ill-defined situations require creative thinking, professionals draw on practical experience in an intuitive manner at the same time as reflecting on their actions, and reflection-in-action is embedded in this process.

He is less convinced by many of the cases used by Schon to exemplify his theory, suggesting that these fail to take account of the complexities of the teaching situations. For example, 'action' is taken only to be the work of the trainee professional. The teaching role of the teacher, while described, is not addressed in the same terms of reflective practice. Eraut also suggests that the examples are presented without adequate clarification of whether, in a given case, reflection-in-action relates to all, or only a part of the situation outlined (including, for example, the student architect drawing the design, or only their consideration of the larger problem of site management). He suggests three possible interpretations: reflection-in-action may relate to the element and the whole (Eraut then sees reflection as being synonymous with thinking); individual parts of a task may be considered action, while consideration of the overall task is reflection-in-action; or

reflection may be seen as a metacognitive process, which informs decisions about what to do next. He concludes that Schon moves between the three possible meanings, thus rendering the term reflection-in-action ambiguous and difficult to interpret.

Reflection-on-action is less problematic for Eraut. This he sees as referring to post-hoc consideration of professional action which allows action to be considered within the professional's existing understandings and as having the potential to contribute to longer-term learning. Even here, however, there are overlaps between reflection-in-action in whichever meaning it is understood, and reflection-on-action, especially if professional activity is not just a single event, but continues over a number of sessions. Overall, Eraut suggests that Schon's work is best seen as contributing to theory on meta-cognition in professional practice.

3.7 Competence and expertise

3.7.1 The novice to expert model

Some models of professional competence have their roots in the field of artificial intelligence and continuing work to develop expert systems which can mirror human thinking and decision-making. One influential example of this is the work of Dreyfus and Dreyfus (1986). Their philosophical approach is that humans understand the world by 'picking up' flexible styles of behaviour, rather than learning facts and applying them. Throughout their discussion of the quantitative model of developing competence, they repudiate the behaviourist approaches towards competence, focussing instead on perception, understanding and decision-making. They present the concept of competence as a step on a continuum of professional development from novice to expert. They chart five steps on the novice to expert continuum (see Table 3.2).

Table 3.2: From novice to expert

Skill level	Components	Perspective	Decision	Commitment
Novice	Context free	None	Analytical	Detached
Advanced beginner	Context free and situational	None	Analytical	Detached
Competent	Context free and situational	Chosen	Analytical	Detached understanding and deciding. Involved in the outcome
Proficient	Context free and situational	Experienced	Analytical	Involved understanding. Detached deciding.
Expert	Context free and situational	Experienced	Intuitive	Involved

Dreyfus and Dreyfus (1986: 50)

The 'novice' can recognise features of a task, so that s/he can follow the rules, but is unable to go beyond them. This is typical of the student in first or early second year, who rigidly applies a formula, but does not know what to do if something goes wrong. The 'novice' has no coherent sense of the overall task. The 'advanced beginner' uses experience as well as rules to allow slight variations in a task: the student still does not have an overview of what they are looking for or trying to do and still sticks to the 'rules' but interprets them a little. At the level of 'competence' there is a reducing reliance on rules, and more reliance on integrating knowledge and skills. There is the ability to analyse a situation and organise approaches to a problem, and vary behaviour in order to achieve not just one task, but overall success (e.g. in client management). What is still missing is a sense of what is important.

Dreyfus and Dreyfus consider competence to be the climax of rule-guided learning, where behaviour has not yet become the semi-automatic reflexive behaviour of the proficient practitioner. They suggest that, at best, computer 'expert systems' can only work up to competence level because they require rules to function and complex questions do not lend themselves to mathematical analysis in the same way that well defined simple questions do. Beyond competence come levels of 'proficiency' and 'expertise', by which time the entire

process is internalised with a development towards so-called 'intuitive' decision making.

Dreyfus and Dreyfus mirror some of Schon's conclusions, stating that experts cannot articulate rules. Indeed, at this level, experts are not following rules, instead drawing on their previous knowledge of large numbers of special cases. If an expert is asked for rules, s/he will go back to level of a beginner, stating rules which s/he no longer uses. Thus they too claim a substantial role for intuition in professional practice.

3.7.2 The novice to expert model in practice

Benner (1984) applied the Dreyfus' model to nursing. In an ethnographic and interpretative study, she used a critical incident approach, asking dyads of experienced and inexperienced nurses to describe their thinking, actions and feelings when confronted with clinical situations. She identified six areas of practical knowledge which develop as nurses progress from novice to expert status. These areas were defined as: the ability to make graded qualitative distinctions; the development of common meanings; professional assumptions; perceptions and sets; increasing awareness of paradigm cases and personal knowledge; professional maxims; and unplanned practices. Graded qualitative distinctions develop as nurses recognise which factors are relevant and which critical to a patient's well-being. Common meanings are the within-profession understandings developed through the use of professional jargon and spoken and written short-cuts which help to smooth and speed communication. Assumptions, perceptions and sets are the tacit underlying values adopted by the profession. Paradigm cases are those which have a deep impact on the individual and lead them to ground aspects of the lessons learned in their personal knowledge. Maxims are propositions which are generally held as truths within the profession. Finally, unplanned practices are those which were not part of the professional's

expected role, but which they perform frequently because they are the only person available. Each area undergoes change and results in learning, and increasing professional capability although the changes are dependent upon the individual, their role and their working context.

In describing in an applied form a way in which the Dreyfus model can be applied to professional practice, Benner suggests that the clinical (that is, practical) knowledge underpinning clinical practice is frequently overlooked in the search for technological and technical advances, but that it is at the heart of competent practice.

3.7.3 Expert performance

Chi, Glaser and Farr (1988) compared expert and novice performance with computer models, presenting a number of hypothetical case studies, which consider cases as diverse as judges and social scientists. Their findings support Dreyfus and Dreyfus' conclusions. In their overview of the book's findings on expertise, Glaser and Chi (1988) identify seven characteristics of expertise which are relevant to concepts of competence.

1. Expertise is domain specific. There is little evidence that it is the expert's thinking alone which is important but the breadth and organisation of knowledge within a domain which gives rise to expertise.
2. Experts create patterns of their domain which are extensive and meaningful. Again, this is dependent upon organisation of their knowledge base.
3. Experts are faster than novices – they solve problems and perform skills rapidly with few errors. This may be the result of practice and over-learned routines, which can reduce the memory load required for a task and frees this for other work. It may be because they recognise patterns which can suggest

the best way of proceeding based on organisation of previous knowledge and memory for events and situations.

4. Experts have better short-term and long-term memory than novices. The automatic nature of much of their action uses up memory space which, in the novice, is used to process data involved in a task.
5. Experts represent problems in their own domains according to deep principles rather than surface characteristics. This allows mapping of individual problems against conceptual categories in a more efficient manner.
6. Experts analyse problems qualitatively, trying to understand a problem as a whole rather than reduce it to atoms of the whole. In building a mental representation, they can then enter relationships between different aspects of a problem and then add constraints (potential reasons for the problem) which help to solve the problem itself.
7. Experts have strong self-monitoring skills. They appear to have a greater awareness of when they make mistakes, why they have not understood something and when to check their solutions. Superior self knowledge and self-monitoring is, to a large extent, a result of greater domain knowledge and differences in how this knowledge is represented by the expert as compared with the novice.

3.8 Conclusion

Defining competent professional practice is a complex activity. Much of this chapter has considered models of competence and models of expertise, focussing on knowledgeable and skilled behaviour. The NVQ model appears to offer a simple answer to identifying and measuring competent behaviour, but when examined in detail, it lacks the ability to account for complex decision-making. Gonczi acknowledges the tensions between differing approaches to assessing competence and addresses many of the concerns raised with, but largely disregarded by, Jessup and Burke in their writing. He presents competence as

resulting from a complex combination of knowledge, attitudes, values and skills which a professional uses to interpret and act, although operational competence is still at the heart of the model he presents.

The McBer work appears to assert that underlying competences are attributes and traits which are dificult to train or change, suggesting that recruitment of the 'right' material is possibly the most important aspect of developing competence. Unfortunately it fails to make a practical case for the usefulness of the model in developing competence.

The approaches of Schon, Dreyfus and Dreyfus and Glaser and Chi appear, at a surface level, to be going backwards. Intuition does not initially appear to be compatible with professionalism, as professionals might be expected to know what they are doing and be able to explain this. These authors are, however, speaking of informed decision-making which does not always reach the levels of linguistic processing in the brain and which demonstrates a level of understanding and cognitive processing which is difficult to articulate. The difficulties with these approaches are the opposite of the difficulties inherent in the NVQ approach to competence: it is almost impossible to map the models onto measurable aspects of competent practice. Theoretical concepts are important in understanding underlying human knowledge and actions, but they are difficult to spell out, quantify or measure in the identification of what is and is not competence.

Eraut summarises the diverse approaches to identifying and measuring professional competence by stating that at least two dimensions must be considered, these being scope and quality. Scope defines the range of working practice in terms of roles, tasks and contexts. Even here, there are difficulties in professional practice as work is not routine and roles, tasks and contexts will change in line with the increasing knowledge base of a profession, advances in technology, changes in social policy and the individual's career path. The quality

dimension concerns judgements of increasing capability in existing and potential roles, tasks and working environments. This concept produces difficulties in measurement, precisely because it is qualitative and therefore reliant on judgement. Eraut suggests that professionals have little difficulty in recognising competence, but find it extremely difficult to spell it out.

Each of the approaches outlined above has had some influence, either overtly or covertly, on the approaches adopted to developing competence in a range of differing professions. Eraut (1994) suggests that professional knowledge cannot be characterised in a manner which is independent of the learning situation. Indeed, rather than considering knowledge as something which is first learned and then applied, professional learning takes place during use. The following chapters attempt to trace how an SLT student can acquire that professional knowledge and become a competent practitioner in the field of speech and language therapy.

Chapter 4: Competence in speech and language therapy

4.1 Introduction

SLT, in common with many other professions, has produced a number of publications considering aspects of professional competence. Gailey (1988) presents a philosophical discussion on the nature and development of clinical competence and expertise. RCSLT issued its first professional standards guidelines in 1991. van der Gaag and Davies in 1991 and 1992, and Kamhi in 1995, published papers on the knowledge, skills and attitudes of SLTs. Roulstone (1995; 2001) presents a multi-method approach to identifying SLT expertise in diagnosis and evaluation of children's communication disorders and Williamson is involved in an on-going 'competencies project' funded by RCSLT (Williamson, 2001).

This chapter outlines some of the key SLT publications on competence and discusses these in relation to the theoretical approaches to competence outlined in the previous chapter. It is clear that there are difficulties inherent in defining competence in the publications reviewed. In part, this is because the differing philosophical approaches to identifying competence noted in the previous chapter are mirrored in SLTs work. Possibly it is also because of the need to consider the 'here and now' aspects of competence along with the recognition of a need for a longer term view of competence, possibly because of changes in the types of knowledge, skill and attitude required by SLTs at different times in the profession's history and not least, because of the purposes for which the publications were intended.

4.2 SLT and professional competence

Gailey was an early British author to discuss explicitly the issue of competence. She suggested that the SLT professional had always had a working consensus on the nature of professional competence, but was only just at the point (1988) where this was being formalised. Working as a part of a group tasked by the

professional body, the College of Speech Therapists to produce a set of guidelines for professional practice, in response to public government concerns over alleged lack of accountability of the professions, she suggested that the absence of a formal statement regarding SLT competence up to that point had three main causes. Firstly, there was rapid growth in the field of SLT work and in theoretical understanding of the nature of communication disorder, so the types of competence required were changing rapidly. Second, the profession had maintained a stance that autonomy and individual approaches to practice were desirable, especially in areas where theoretical knowledge was sparse or changing rapidly, thus there was probably some element of maintaining a professional mystique. Thirdly, and pragmatically, inadequate staffing numbers had always constrained strategic thinking and planning.

The work of the professional body which she described resulted in the first comprehensive professional standards guidelines for SLTs in the UK: Communicating Quality (CSLT, 1991; RCSLT, 1996a). Communicating Quality (CQ; CQ2) publishes information for SLTs, clients and employers on the standards to be expected of the individual professional and of the service. While not addressing what 'competence' is explicitly, it provided a code of ethics and guidance on client groups, the working context, the responsibilities of the SLT and the service provider.

4.3 SLT studies on competence

4.3.1 Stengelhofen's study

Stengelhofen is a senior academic in the SLT field and her (1984) study was carried out in order to identify ways in which students' educational experience could be made more relevant for their future careers. She carried out a series of observations of four clinicians working with communicatively disabled clients, and followed these up with interviews to elicit the knowledge, professional and technical skills and attitudes which underpinned the surface clinical actions of the therapists. From this, Stengelhofen developed a model of professional

practice (see Figure 4.1) where each level influenced the others and all were influenced by the professionals' experience.

Figure 4.1: Stengelhofen's model of professional practice

Surface level	TECHNIQUES AND PROCEDURES: Includes skills in interpersonal relationships	
First deep level	KNOWLEDGE AND UNDERSTANDING: Speech and language pathology Linguistic knowledge Psychological knowledge Child development knowledge Sociological knowledge Clinical medicine knowledge KNOWLEDGE AWARENESS	ALL LEVELS INFLUENCED BY: Life experience Undergraduate learning Work experience Continuing education Relationship with employing authority Working context (e.g.school, clinic, etc.)
Second deep level (giving meaning to what is done and influencing use of knowledge and techniques and procedures)	ATTITUDES TO: Relationships with clients Relationships with parents Relationships with other professionals Relationships with employer Planning and evaluation Professional work and career future MORAL VALUES	

The model incorporated details of each of these levels, which could be used as a basis for measuring surface output (performance) and knowledge and attitude bases (competence, in her terms), although as presented the model was still at a high level of abstraction.

Stengelhofen found that the acknowledged value of the knowledge base from supporting disciplines varied according to the therapist's working experience. Clinicians did not always identify elements of their practice in relation to the disciplines studied, even when they had been observed using very particular theoretical approaches (for example, while behaviouristic psychological approaches to learning in the clinical situation were observed in all practice, psychology was placed only third in a hierarchical list of useful disciplines in undergraduate education).

Stengelhofen draws upon Argyris and Schon's (1974) work in hypothesising that clinicians utilised much of their theoretical knowledge tacitly without

drawing it to the forefront of their cognitive and linguistic rationalising of clinical practice. Her later work (Stengelhofen, 1993) utilised these findings to address clinicians' understanding of their role in student education.

4.3.2 van der Gaag and Davies' study

Slightly later than Stengelhofen's initial work on competence, and at the same time as RCSLT was working on the first Communicating Quality document, the UK government was also expressing interest in the identification of competence in professional practice. This led to a Department of Health funded SLT project intended to specify simple, easily identifiable aspects of knowledge, skill and attitudes which could be used in workforce management, prompted by the question of:

> whether the knowledge and skills base of existing professionals was necessary and sufficient for the demands of contemporary health services (Davies and van der Gaag, 1992a: 210)

van der Gaag and Davies (1992a; 1992b; Davies and van der Gaag 1992a, 1992b) used a combination of Delphi, nominal group and survey techniques to identify views on professional competence of SLTs working in three specialities in the UK: paediatrics; learning disabilities and adults with acquired neurological disorders. This work complements that of Stengelhofen, in that, while hers involved direct observation and in-depth interviews with small numbers, van der Gaag and Davies included a total of almost seven hundred SLTs at some point in their consultation process. van der Gaag and Davies found a strong consensus about the knowledge base for each of the three areas of clinical practice (Table 4.1). Clinicians identified core knowledge items essential for competence across all specialisms at a super-ordinate level with additional domain-specific knowledge requirements dependent upon the contexts in which therapists work.

As suggested earlier by Eraut (1984), Stengelhofen (1984) and Schon (1991), van der Gaag and Davies concluded that the exact nature of the SLTs' knowledge requirements and the extent and depth of the knowledge were

context specific. Further aspects of their study identified consensus on the skills base of SLT, within the domains of therapy, teaching, interpersonal relationships and administration. As with the knowledge bases, profession-wide skills in each of these super-ordinate categories were supplemented by specific skills needed for work in each of the specific areas of paediatrics, learning disability and acquired adult neurological disorders. van der Gaag and Davies noted that SLTs needed to draw on their knowledge-base in order to work effectively with clients in many areas of practice. They also noted that some skills called for a complex integration of knowledge and practical application.

Table 4.1: Super-ordinate domains of knowledge and skill required by a competent SLT

Knowledge:	Speech and language Psychology Medicine Education policy Client and service management
Skill:	Therapeutic Teaching Psychological Client and service management

Finally, van der Gaag and Davies investigated the attitude base considered to be essential to competent practice in SLT. They note that attitudes are even more difficult to measure than clinical skills. As a result of their study, however, they found a strong consensus on the attitudes and/or attributes essential to professional competence in SLT (Table 4.2).

Table 4.2: Core attitude base required by a competent SLT

Desire to learn
Flexibility
Empathy
Positiveness
Professionalism
Self awareness
Enthusiasm

van der Gaag and Davies suggest that the attitude base of the profession is not static, being subject to changes in social culture, and organisational structure in particular. They identify the emergence of attitudes 'necessary for responsible action' (van der Gaag and Davies 1992b: 330) including assertiveness, realism,

perseverance and the ability to compromise as being at least as important in the SLT's working life as the 'gentle attitudes' (van der Gaag and Davies 1992b: 330) of patience, idealism and empathy.

They did discuss whether attitudes were in fact attributes, that is, relatively fixed aspects of the person's character (perhaps reflecting Spencer and Spencer's (1993) approach), or whether attitudes were context sensitive, as suggested by Dreyfus and Dreyfus (1986). As the attitudes identified here do not appear to be specific to SLTs, rather, being appropriate for almost any professional role, van der Gaag and Davies concluded that professional context of SLTs' work must influence how attitudes are judged in an assessment of competence although they came to no clear conclusion on whether such attitudes were intrinsic personal characteristics.

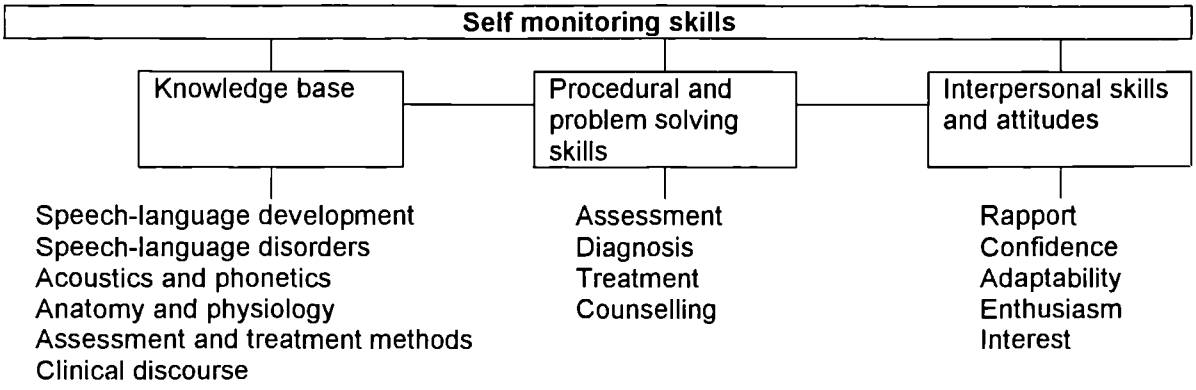
van der Gaag and Davies' findings did not achieve the desired outcome of the Department of Health (van der Gaag, personal communication), as they failed to specify simple, easily identifiable aspects of knowledge, skill and attitudes. Instead, what their study did do was demonstrate the complexity of professional work within the SLT profession at that time.

4.3.3 Kamhi's study

van der Gaag and Davies' work is complemented by that of Kamhi (1995) from the US. His work was intended to encourage discussion on how clinical expertise might influence therapy outcomes in SLT. He identified four areas of 'clinical expertise' drawn from samples of clinicians and students working in a variety of clinical settings. Of these areas, knowledge, technical skills and interpersonal skills/attitudes match those identified by Stengelhofen and van der Gaag and Davies very closely, while 'clinical philosophies' (such as a commitment to including carers in therapy, creating an appropriate client centred environment, seeing the need for functional and not just clinic based communication) indicated an underlying values base which would support practice and correspond to Stengelhofen's second deep level of competence.

In his work, Kamhi found that knowledge-based factors were mentioned less frequently than other factors, but on questioning clinicians he found that 'an adequate knowledge base was assumed' (1995: 353). He also noted that inter-personal and attitude factors were rated as being significantly more important than technical skills, and that the technical skills which were rated highly (objective setting for example) were highly reliant on knowledge. His model of the components of clinical expertise (see Figure 4.2) is very similar to those of Stengelhofen (1984) and van der Gaag and Davies (1992a).

Figure 4.2: Kamhi's components of clinical expertise



The clinicians he surveyed stated that they had a greater knowledge base on graduation, but gradually became confident in using their own judgement and made decisions more quickly and accurately as they matured. Kamhi suggests that clinical expertise relies on:

> a certain comfort level with one's knowledge base, technical/problem-solving skills and interpersonal skills/attitudes (1995: 354)

Kamhi's view of clinical expertise is that it involves the fusion of the personal self and the clinical self. The novice (student) will have a clear division between these two aspects of self, while the expert has knowledge, skills and attitudes which have gradually evolved to become an integral part of the person. He hypothesised that clinical decision-making and clinical effectiveness would increase as a clinician incoporated the 'clinical self' within the 'personal self'. As with van der Gaag and Davies' work, this can be seen to fit most closely within the Dreyfus brothers' model of developing competence and expertise.

4.3.4 Roulstone's study

Roulstone's (1995; 2001) work takes concepts of developing competence and expertise a stage further. She describes a study on clinical decision-making in which she aimed to find the answers to a number of questions about how practising SLTs worked, specifically:

- What factors were considered in new referrals
- How these factors were defined, categorised and prioritised
- What hypotheses guided SLT's investigations
- What levels of consensus existed between SLTs

Through the study, she hoped to make the clinical decision-making process explicit, in order to provide a model for junior members of the SLT profession and to act as a stimulus for reflection in more experienced individuals. Her methodology involved a sophisticated multi-modal qualitative approach to data collection, involving semi-structured interviews, respondent validation, a group workshop and a modified Personal Construct Psychology approach.
She developed a model of clinical decision-making influenced by five factors. Firstly she used the Dreyfus brothers' model (Dreyfus and Dreyfus, 1986) to consider the clinicians' levels of expertise. Secondly, she discussed the structure of clinical tasks in terms of complexity and ambiguity. Thirdly she identified aspects of the social and institutional context in which a clinician works, such as the level of detail available in referral information, availability of equipment and the amount of time available for client contacts. Fourthly, depending upon the relative stability of the clinician's work she applied Schon's (1991) concepts of reflective practice. Finally, she noted the influence of clinicians' personal ideologies: their attitudes to their work.

The outcome of the study was a complex algorithm for clinical reasoning in work with paediatric cases, in which a child's presenting communication difficulties and clinical history are balanced with the child's current context in order to decide on the level of priority to assign to the case. Roulstone stresses that the

decision-making process in clinical work is necessarily at a high level of complexity which resists being broken down into easily identifiable chunks of skill. In broad terms, she states that:

> Simplistically, the results of most of the research can be summarised by saying that, through experience, knowledge acquired as a novice becomes integrated and organised to provide easy access for the working practice of the individual (1995: 29)

Her model can be applied with increasing levels of imagination as the clinician grows in confidence and expertise. She found, in line with Dreyfus and Dreyfus (1986) and Glaser and Chi (1988), that specific rules can de-skill experienced practitioners. She regards her model not as an exact set of directions on a prescribed route, but as a map of the process, with plenty of opportunities for taking different routes.

4.3.5 RCSLT competencies project

The SLT professional body, RCSLT, is currently funding a project designed to establish the 'competencies' needed to practise as an SLT in the UK. This may appear to be repeating work by earlier authors. Indeed, Williamson (2000a) echoes many of the previous studies, in suggesting that estimating professional competence might best be achieved by working with therapists to analyse their judgement and decision-making, as was suggested by van der Gaag and Davies in 1992, and done by Stengelhofen (1984), Kamhi (1995) and Roulstone (1995). Initial publications of work in progress (Williamson, 2000a; 2000b; 2001) do not, however, mention any of the SLT work reviewed above.

The project aims are:

> To develop .....
> - a model of professional competence reflecting the richness and complexity of the profession;
> - a clinical competencies framework mapping out professional performance aims, together with the underpinning knowledge, understanding, skills and values;
> - a way of reflecting competence and clinical competencies within grading. (Williamson, 2000b: 3)

The project has its precursers in Gailey's (1988) and RCSLT (CSLT, 1991; RCSLT, 1996a) publications. It was intended to specify a 'Scope of SLT Practice', as is documented in other countries (CASLPA,1998; ASHA,1999; SPA, 2001a; 2001b). In addition, and more importantly to many clinicians, as a result of a long running legal action, SLT salaries were about to be upgraded, so there was a financial incentive to identify individual working roles. The final aim, directly related to this regrading, therefore has the potential to overshadow the other two.

Williamson, using the NHS vocabulary of clinical governance, has presented her definition of professional competence as:

> Doing the right thing in the right way, with the right person, at the right time, in the right place and for the right reason. (Williamson, 2000b: 9)

The project has involved a wide range of consultation across the UK and Williamson is continuing to develop the detail of her approach to competence incorporating the views of the profession gathered at a series of 'road shows' as well as through other personal contacts (Williamson, 2001). She identifies super-ordinate categories of SLT work (clinical work, research, training, management, supervision, mentoring) and contextualises these in terms of 'core competencies' (needed by all SLTs) and 'specific and differentiating competencies' needed in differing working roles and contexts, taking into account the professional's performance, but also the underpinning knowledge, skills and values.

Skills include not only 'technical and professional skills' but also 'emotional skills' (Williamson, 2000a: 23), apparently referring to a clinician's attitude to their professional life and work. Categorisation of these 'skills' includes self-awareness, self-regulation and motivation as well as empathy and adeptness in relationships. Williamson also identifies 'professional values and attitudes', including under this single heading a belief in the profession, adherence to the Code of Ethics, acceptance of one's own limitations and responsibility towards the client.

As the project comes to a conclusion, Williamson (2001) appears to be presenting a 'central framework' where 'current competence' is directly related to the SLT's current post, but is embedded within a broader area of 'capacity' (see Figure 4.3). In addition, 'competencies' are identified at the levels of task, process and judgement, and decision-making (Figure 4.4) with the judgement and decision-making competencies being identified as being the least visible, but most important and hardest to measure.

Figure 4.3 Williamson's competency framework model

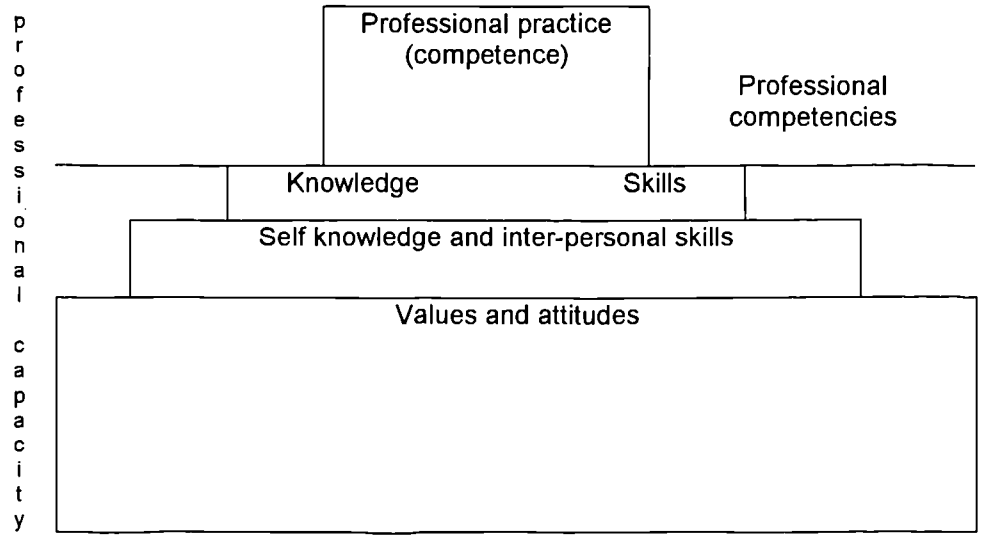
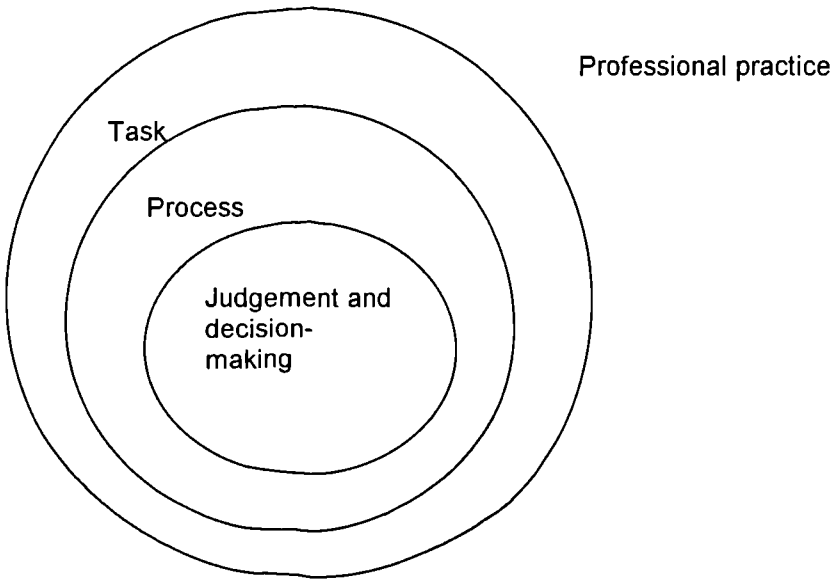


Figure 4.4: Cross-section of Williamson's professional practice level



Whether this model can be broadened, to include increasing quality as well as scope of practice, and development of expertise, remains to be seen. On the whole, the model appears to be best suited to be used as a management tool, which, in part, is what the project aimed to produce. It must be stressed, however, that all the work quoted was part of the consultation process, so changes may well occur before the project is complete.

4.4 Critical evaluation of SLT publications on competence

Each of the SLT publications on competence presented has a common aim of attempting to make explicit the nature of competence in the SLT profession. Gailey wrote an overview of the profession's approach and attempted to outline the need, as she saw it, for the profession to be more explicit about its competence base. This paper was based in the work of the professional body, driven by government views on the accountability of professions. It is relatively light on detail, and was more a descriptive than a philosophical consideration of the nature of competence.

The studies described all made an attempt to identify the nature of competence and all identified similar super-ordinate structures of knowledge, skill and attitude as the component parts of competence. All the authors found skill (and especially technical skill) the easiest aspect of competence to identify, but also the least characteristic aspect of competence in itself. All of them considered a person's attitude and attributes to be a key to competent clinical practice.

van der Gaag and Davies encouraged their respondents to be explicit about the knowledge, skills and attitudes believed to be necessary for competent practice, and as a result produced extensive lists of items in each category, with the level of agreement reached on each item. van der Gaag and Davies were, however, clear that these lists were not comprehensive, and that competence was an over-arching concept which encompassed the items listed, rather than being constructed entirely from them. The nature of competence was also identified by them as being a changeable concept for the profession as a whole and for individuals within the profession.

Williamson's work had a similar motive to that of van der Gaag and Davies' work: to specify job competence. In this aspect, it appears to be the study most closely related to an occupational standards model, with an attempt to identify job related skills and using the language of skills to describe aspects of competence which might be more appropriately defined as personal characterstics. Like van der Gaag and Davies, however,she has not supported a narrow occupational standards approach, and her model of competence embedded within capacity may be the first strand of a concept of competences which, while developmental and progressive, are measurable at differing points in a clinician's career. If so, it fits well into the Australian model of competence outlined by Gonczi (1994).

Within the categories of knowledge, skill and attitude there were variations of definition. Stengelhofen's theoretical bases were those of Schon and Kolb. She identified a knowledge base which she believed to be largely unrecognised by her subjects, despite it being evident in their practice. Kamhi suggested that rather than being unrecognised, knowledge was an assumed aspect of competence and expertise, which respondents did not feel the necessity to make explicit, a point also accepted by Roulstone. Kamhi's list of 'procedural and problem-solving skills' could be seen in the knowledge base identified by van der Gaag and Davies, and Kamhi separated out 'interpersonal skills and attitudes' from 'clinical philosophies'. Williamson, in contrast, included under the skill umbrella 'emotional skills', self awareness and motivation, which other authors identified as part of the attitude base of competent practice.

Roulstone's work was explicit in its use of expert systems to consider competence and expertise and it is unsurprising therefore that she accepts the Dreyfus model as her baseline. She, together with Kamhi, was the author who made the clearest outline of competence as being embedded within ithe context of the clinican's work and experience.

4.5 Conclusion

In summary, the SLT studies are investigating competence for differing reasons and their findings therefore reflect the authors' particular agendas. Despite the differences of emphasis, however, there is a large degree of commonality in the models presented. Aspects of each of the theoretical positions outlined in the previous chapter can be found throughout these studies. There is a stated intention to quantify aspects of competence in most of the studies, which reflect some aspects of the NVQ model. The concept of competence as capacity for intelligent performance as outlined in the Australian model is reflected in the various authors' statements on the need to consider competence as a whole, rather than atomistically. There are some implicit, and sometimes explicit statements that particular personal characteristics are a prerequisite for competence, as suggested by the McBer school, while the difficulty in identifying the exact nature of competence suggests that much of the knowledge about this is deeply hidden and tacit, as suggested by Schon. Competence as a point on a continuum is a theme of several authors, reflecting the Dreyfus and Dreyfus approach.

All of the authors were in agreement on one thing. Competence is easier to recognise than it is to describe.

Chapter 5: Higher education, competence and speech and language therapy

5.1 Introduction

Higher education (HE) was, in its earliest form in the UK, designed to train people to enter the professions (law, medicine and the church), but it was also understood to have a liberating role (hence the term 'liberal education'). It was expected to develop the whole person, in terms of increasing knowledge and understanding; intellectual virtues (e.g. caring about knowledge for its own sake); intellectual skills (the ability to acquire knowledge); developing imagination; the ability to be self-reflective; increasing moral virtues and habits; developing social and political involvement and personal integrity and authenticity (Pring, 1995). As long as it was available only to a small proportion of the population, HE could maintain this level of intellectual and personal aspiration, but with the move toward a much less exclusive HE system, a dichotomy has developed between those who identify the educated person as someone with the ability to engage in theoretical and aesthetic activity (e.g. Lyotard, 1979, tr 1984) and those who believe that education should engender vocational skills or the competence to be enterprising and economically aware (e.g. NCIHE, 1997).

The nature of degree-level education has necessarily changed, with the advent of a mass HE system, to accommodate a much broader range of subjects. The UCAS handbook (UCAS, 2001) offers courses from acupuncture through speech and language therapy to yacht design, many of which would have been considered inappropriate for degree level study prior to the Robbins report (CHE, 1963). All vocational or work-focussed degrees imply or state the need to develop competence specific to the employment focus of the degree. In addition, one of Dearing's aims (NCIHE, 1997) was to ensure that all students developed work-orientated skills which would be of benefit to them and to employers on the completion of their studies.

This chapter outlines approaches to competence as a part of higher education, relating this to two studies of the SLT curriculum and to current SLT course documentation, in order to identify the place of competence in the current SLT curriculum.

4.2 Competence in higher education

Lyotard (1979, tr. 1984), laments that the desired social goal for HE is now that it should contribute to the 'performativity' of the social system, rather than the development of knowledge and ideas. He suggests that HE is increasingly required to produce skilled professionals

> to create skills, and no longer ideals – so many doctors, so many teachers ..... The transmission of knowledge is no longer designed to train an elite capable of guiding the nation towards emancipation (1984: 48).

However, Barnett (1994) suggests that competence as an aim of HE is not intrinsically problematic unless either it is defined too narrowly and/or it becomes a dominant aim of HE, diminishing other equally worthwhile aims. Barnett outlines what he describes as rival versions of competence in HE (see Table 5.1).

Table 5.1: Two rival versions of competence

	Academic competence	**Operational competence**
Epistemology	Know that (is our knowledge being advanced?)	Know how (what does it enable us to do?)
Situations	Defined by academic field	Defined pragmatically
Focus	Propositions	Outcomes
Transferability	Meta-cognition (transferring skills from one cognitive situation to another)	Meta-operations (transferability across domains of performative skill)
Learning	Propositional	Experiential
Communication	Disciplinary	Strategic
Evaluation	Truthfulness (veracity)	Economic
Value orientation	Disciplinary strength	Economic survival
Boundary conditions	Norms of intellectual field	Organisational norms
Critique	For better cognitive understanding	For better practical effectiveness

Barnett (1994: 160)

Operational competence (that which, to a large extent, is the competence likely to enhance the country's economic performance) is in competition with the academic form of competence. There is a clear difference between the 'old' values of academic competence, which mirror Pring's (1992) aims for education and the 'usefulness' values of operational competence. Barnett suggests that the opportunity to develop 'intellectual excellence' was only ever accessible to the few, and, with the advent of a mass system of HE, the move toward what he defines as operational competence (and which Lyotard sees as performativity in terms of the HE system) is unsurprising.

> Language typifying a social practice such as higher education does not change without cause. Nor are the causes simply a matter of idiosyncratic innovations. Language is social and terms are to be taken up in a widespread way because they have societal resonances and uses. (Barnett, 1994: 157)

The social resonances in the varying use of the term 'competence' have their roots in the increasing demand for accountability of HE to its major funder, the state. To a large extent this is an understandable demand. The state invests large sums of money into the HE enterprise and in return it expects value for money in its own (largely operational) terms. Barnett (1994) develops his argument into a highly abstract theoretical exposition, but in summary, he suggests a third, super-ordinate approach to the outcomes desirable from a student's experience of HE (see Table 5.2). He develops a theme of meta-cognition which will allow students to accommodate both of the existing approaches to competence, but, further, allow them to develop the capacity to frame a situation in a number of ways and to identify and use appropriate skills in the situation as it is framed. To do this, students require information in order to acquire knowledge, but in order for this to become knowledge, they need to apply insight, interpretation and understanding to that information, as 'Without insight, interpretation and understanding, information itself is blind' (Barnett, 1994: 42).

Table 5.2: Barnett: beyond competence

	Academic competence	**Operational competence**	**Life-world becoming**
Epistemology	Know that (is our knowledge being advanced?)	Know how (what does it enable us to do?)	Reflective knowing
Situations	Defined by academic field	Defined pragmatically	Open definition (with use of multiple approaches)
Focus	Propositions	Outcomes	Dialogue and argument as such
Transferability	Meta-cognition (transferring skills from one cognitive situation to another)	Meta-operations (transferability across domains of performative skill)	Metacritique
Learning	Propositional	Experiential	Meta-learning
Communication	Disciplinary	Strategic	Dialogue
Evaluation	Truthfulness (veracity)	Economic	Consensus
Value orientation	Disciplinary strength	Economic survival	The common good (defined through consensus)
Boundary conditions	Norms of intellectual field	Organisational *norms*	Practicalities of *discourse*
Critique	For better cognitive understanding	For better practical effectiveness	For better practical understanding

Barnett (1994: 179)

Barnett's aspiration for HE is that it should provide

> a meta-education in which students develop the emancipatory capacities to call upon a range of skills in the context of their reading of a situation (1994: 88).

Thus, he is still seeing the ideal education as a liberating experience, although the nature of the liberation is now presented in abstract concepts of 'life-world becoming' or long term opportunities for personal development. While it appears idealistic in view of the many pressures for HE to deliver operational competence (e.g. NCIHE, 1997), this philosophical approach to considering the roles of HE is useful in framing the discussion on education for developing competence in professional practice below.

5.3 Competence in pre-qualifying professional education

In devising educational programmes for students aspiring to enter professional practice, there are many areas of commonality between professions. Bines (1992) presents a set of three models of professional education: pre-technocratic; technocratic and post-technocratic (see Table 5.3).

Table 5.3: Models of professional education

Model	Characteristics
Pre-technocratic	Practical routines. Mastery of facts and routines. Work-place learning. Experienced practitioners act as instructors. Employer dominated learning/ national curriculum.
Technocratic	Systematic knowledge base. Academic subject specialists plus former practitioners deliver HEI based curriculum. Interpretation of knowledge base and development of 'principles and practice'. Supervised work-place practice. Experienced practitioners act as practice supervisors HEI control over content. Tension between academic rigour and professional relevance.
Post-technocratic	Knowledge for practice. Acquisition of professional competences. Systematic reflection on practice. Practical dominates the curriculum. Professional practitioner-educator operate in HEI and practice setting. Subject specialists have negotiated role based on professional credibility or research. Partnership between HEI and employers through learning contracts.

Source: Bines, 1992: 14-15

A pre-technocratic model is largely equated with apprenticeship. Learning is predominantly in a work context, with acquisition of accepted facts and routines, but little opportunity for innovation. It is, Bines suggests, 'characterised by a tight and instrumental focus on professional requirements and competences which are not seen as problematic' (1992: 12). The technocratic model is one where learning

is incorporated within HEIs, with three strands to student learning: acquisition of a knowledge base; in-house application of this knowledge to practical issues within the HEI and finally, supervised practice on placements. Here students can easily experience a divergence between the theory as taught in university and the practice they see in the placement, and as a result find difficulty in relating the one to the other. Bines suggests that the placement in this model is seen by academics as second in importance to the academic university-based experience. The third, post-technocratic, model emphasises the development of competences through experience of, and reflection on, practice, with the placement being the central point of learning.

These models are not so easily separable in practice, however. 'Supervised practice', for example, appears in both technocratic and post-technocratic models and within many health care degrees, study approaches might be identified from each model. Facts are presented for mastery and, as degrees are now funded through the National Health Service budget, there is some move back to employer-dominated learning (pre-technocratic). There are academic subject specialists and practitioners with academic credentials direct courses (technocratic) but nevertheless knowledge for and of practice (post-technocratic) is a goal of professional bodies (e.g. RCSLT, 2000). As a result, the models as presented are over-simplistic as an explanation for professional education for practice.

5.4 Competence in the speech and language therapy curriculum

As outlined in Chapter 2, the academic curriculum for SLTs is guided by these varying professional considerations and constrained by the need for professional accreditation. International agreement has led to the publication of guidelines on course content in the areas of language sciences, bio-medical sciences, behavioural sciences and speech pathology and therapy (see Appendix 1), which are broadly accepted across the developed world through the work of the International Association of Logopaedics and Phoniatrics (RCSLT, 2000). Degree

level education was hard won (e.g. CST Bulletin,1964), but is now an accepted necessity for entry into the SLT profession in most developed countries (IALP, 2001). The aims of a speech and language therapy degree are, nevertheless focussed on professional capacity and competence: to enable a student:

> to demonstrate a core theoretical understanding of a range of communication and related disorders, and the theoretical frameworks underlying the principles of assessment, intervention and management of individuals with these disorders and a core of generally applicable clinical skills (RCSLT, 1996a: 233).

Accreditation by RCSLT requires a course to develop both academic and professional competence and demonstrate 'a fully integrated whole, where academic theory and practice are intimately blended' (RCSLT, 2000: 3). In the development of 'Benchmark statements' for Allied Health Professions' courses (which include SLT), QAA has also acknowledged the challenge of ensuring that degree qualifications also lead to professional competence and the QAA SLT benchmark mirrors RCSLT guidelines in speaking of:

> the explicit articulation of the academic and practitioner standards associated with the undergraduate award in speech and language therapy (QAA 2001: 2. CL 16/01).

The aim is that the benchmarks developed for SLT will identify the outcomes expected of a graduate with the minimum academic competence to gain an Honours degree and also to satisfy criteria for professional competence.

5.5 Two studies of the SLT curriculum

5.5.1 Stengelhofen's study

Stengelhofen's (1984) work outlined SLT curricula current at the date of writing, as being very much divided between theory and practice, and having constant adding to the syllabus at micro level rather than a focus on the educational process. The

SLT curriculum was, she said, predominantly serialist, discipline based and behavioural in its definition of outcomes, thus creating difficulties for students to integrate and develop their own knowledge. The syllabus had to encompass a wide range of disciplines, it had to be manageable, but at the same time accommodate new content areas and it had to continue to meet the need for fitness for purpose as an academic and a professional qualification. Her snapshot of SLT education in the mid 1980s thus exemplifies the dichotomy between academic and operational competence as defined by Barnett (1994) and fits directly into Bines' (1992) 'technocratic' model, while her aspiration, as seen in her model of competence presented in the previous chapter, was a move towards alternative curriculum models.

Her recommendation was that SLT curricula should accept the challenges inherent in university level education. They should enhance students' ability to see relationships between the various aspects of their course content and to direct their own learning. The relationship between theory and practice needed to become more integrated and bi-directional so that theory and practice were not seen as separate entities and competence was seen to require ability in all three levels of her model. She suggested reducing the reliance on a discipline-based curriculum and moving to a process-orientated curriculum in line with Bines' post-technocratic model and Barnett's (1994) definition of personal development through university education.

5.5.2 Eastwood's study

Ten years after Stengelhofen's observations, the nature and purpose of speech and language therapy education were still being hotly debated. Eastwood (1995), in a study of curriculum documentation and extended interviews with six SLT academics, concluded that the professional core of speech and therapy was dwarfed by other disciplines, rather than developing its own discipline knowledge base, as would be expected of a university level subject. In particular, she

considered that the theory of therapy was missing from SLT courses, and as a result, courses largely failed to present a coherent process-based approach to the core of 'therapy', or developing clinical competence.

She attempted to identify where in the SLT curriculum 'therapy' could be identified. From an analysis of SLT literature, she suggested (1995: 58) that SLT had a number of 'unexamined and uncriticised' assumptions within their curricula and educational practise (for example medicalisation of social problems; ethnocentricity of courses). Her interviews with SLT educators sought their views on how they defined therapy and how they taught the concept to students. Her belief was that too much was inexplicit and atheoretical in the field of SLT. She reported that her respondents all had knowledge about models of therapy, but tended to adopt instead an approach described by her as creative or intuitive. 'Doing therapy is subjective and creative, rather than an intellectual activity' (1995: 112). In addition, she suggested that they were uncertain about what an SLT course was trying to achieve.

In both of these areas, Eastwood's analysis of the interview data she presents can be disputed and her analysis of the responses she received, appears to fit some pre-conceived notion of what she would find. For example, one respondent states 'I have theories about what is wrong with the client and I focus my theory appropriately and see if it's going to be effective, and if it's not I change it' (1995: 110) suggesting that the person concerned had a grasp of a number of different theoretical perspectives rather than none. Another respondent stated 'students at the end of the course have a ... framework of knowledge and practice which enables them to go on developing as clinicians' (1995: 115) which in its generality suggests an expectation of a shared knowledge base between the interviewer and respondent rather than a lack of certainty about course outcomes. Across the interview extracts presented, respondents come across as insightful and knowledgeable, rather than unsure of what they are doing or how they are teaching students to become competent professionals. Eraut (1994) suggests that

professional practice described as intuitive is essentially a cognitive activity and this appears to be the case for Eastwood's respondents.

Her conclusions, for all that, are a challenge to SLT educators and the profession in general. In acknowledging that no pre-qualifying curriculum could include everything required by a future speech and language therapist, she, like Stengelhofen, recommended changes to the SLT curriculum. These included moving away from a fact-based and towards a learning-based curriculum, and making the therapeutic element of SLT courses explicit, by having more detailed outline of aims, content and teaching methods which lead to the development of a competent SLT. These recommendations are firmly embedded in Bines' (1992) post-technocratic model of professional education.

5.6 SLT course documentation circa 2001

5.6.1 Purpose of the survey

Curriculum content as such has retained the same broad discipline areas since formal accreditation of courses was established (Segre, 1950; RCSLT, 2000). To this extent the similarity between Stengelhofen's (1984) and Eastwood's (1995) recommendations may seem to be unsurprising. On closer examination, however, the rapid and extensive changes in higher education in general and the speech and language therapy profession in particular might suggest that SLT educators are out of touch with educational theory and professional contexts (Eastwood, 1995), conservative and unwilling to change.

SLT course documentation is designed to satisfy the demands of professional accreditation and academic validation and is constrained to a large extent by these processes. In producing course documents, however, course teams have the opportunity to present the aims of their course and demonstrate how the curriculum is designed to meet these course aims. The aim of the current survey was to identify how course documentation was designed to achieve the joint academic

and professional outcomes demanded of a graduating student of SLT. It was not possible to do a direct comparison with Stengelhofen's or Eastwood's work as the documentation viewed by them was no longer in the public domain. It was, however, considered important to trace the ways in which current SLT curricula produce evidence of how they go about enabling a student to develop into a competent SLT and to establish if, or to what extent, courses had moved away from the technocratic model identified by Stengelhofen in 1984, or from the dichotomy between discipline and practice based learning which Eastwood asserted to be present in 1995.

5.6.2 Procedure

The author, as a member of a small cohort (around 120) of SLTs teaching on the 21 SLT degree courses in the UK, has a wide network of contacts within the profession. Full documentation for three courses was held personally by the author in her roles as course leader for her own course, external examiner for one course and member of an accreditation panel for a third. RCSLT holds documentation for all UK SLT courses. This is no more than 5 years old and has received professional accreditation within that period. Definitive course documents are public records.

Access to the course documentation held at RCSLT was requested and granted by the RCSLT Academic Officer with the proviso that individual courses should not be identified and confidentiality should be respected. Documents from all but two courses currently undergoing accreditation were made available at RCSLT. Supporting documentation in the form of clinical handbooks for several courses was requested directly from course co-ordinators and colleagues were generous in their willingness to provide this literature. Documents covered the period from 1997 – 2001 (see Table 5.5) and are therefore not an exact paper record of practice in 2001, but were all the accredited documents for current courses. All were published subsequent to Eastwood's 1995 study. All but one document pre-

dated the change of regulation from RCSLT to joint events with CPSM, and all pre-date the publication of the definitive QAA benchmark statements for SLT degrees.

Table 5.5: SLT course documentation surveyed

Course no.	Course Type	Course Document date	Student Handbook	Detailed Module Delivery Documents	Clinical Handbooks/ Documentation
1	3 Year Hons.	1998		✓	✓
2	3 Year Hons.	1999			
3	3 Year Hons.	1997			
4	3 Year Hons.	2000			✓
5	3.5 Year Hons	1997	✓		
6	4 Year Hons.	1997			✓
7	4 Year Hons.	2000			
8	4 Year Hons.	1998	✓		✓
9	4 Year Hons.	1997			
10	4 Year Hons.	Unavailable			
11	4 Year Hons.	1997			✓
12	4 Year Hons.	2000		✓	✓
13	4 Year Hons.	1998	✓		✓
14	4 Year Hons.	1997			
15	4 Year Hons.	2001	✓	✓	✓
16	4 Year Hons.	1998	✓		✓
17	2 Year Masters	1999	✓		✓
18	2 Year Masters	1998	✓		✓
19	2 Year Masters	Unavailable			
20	2 Year Masters	1997			
21	2 Year Masters	1997			

For the purposes of this survey, the author was able to spend three extended working days selecting documentation directly related to the professional, clinical and practical education of students for each course. This was copied so that a documentary analysis could take place in a less space-pressured and more private environment than the small and very busy open plan offices of the professional body's headquarters. All documents were secured in a locked filing cabinet when not in use and were used only for the purpose of this study.

A full content analysis of the documentation was outwith the scope of this study, but course documents were examined to identify how they approached developing knowledge, skills and attitudes of the pre-qualifying SLT and if, or how, this mapped onto concepts of competence. Documentation alone does not give the full

flavour of a course: this is one of the reasons for accreditation visits, where face to face discussion can take place. Documents do, however, enable course teams to present their curricula in the way they consider best fits their own philosophical approach to the education of pre-qualifying SLT's.

5.6.3 Competence in course documentation

Every course document made explicit reference to the development of competence in profession contexts and also addressed the concept of academic competence as outlined by Barnett (1994). The aims of all the courses were, unsurprisingly, very similar. Three examples are reported in Appendix 2. There are differences in emphasis between courses. Course 1, for example (typical of three year honours degrees) makes no explicit reference to developing students' competence in research, while all four year Honours and Masters courses do. Course 16 stresses sufficiency or adequacy of knowledge and skills as a starting point for competent professional life, while Course 18 emphasises the joy of intellectual development. All Course Documents make statements about the core aims of developing professional competence (for example course 1, aim 2; course 16, aims 2,4,5; course 18, aim 4) and the need to integrate theoretical and practical knowledge in order to be able to achieve this.

While statements of course aims are at a super-ordinate level, the detail within each of the course documents allows the reader to track the ways in which the development of academic and professional competence are guided through the structure and process of a course.

The focus and balance of course content has changed considerably since the early days of formal SLT education and since (and probable at least in part as a result of) the work of Stenglhofen and Eastwood. In many courses, the role of disciplines has been substantially reduced. There is still, of necessity, discipline-based learning at early points in most courses and several courses (for example courses

6; 12; 13; 14; 21) extend this throughout the course, but the focus of the curriculum is increasingly applied to the core of speech and language therapy, specifically in order to achieve the development of academic and professional competence identified in all stated course aims.

All course philosophies demonstrated a commitment to developing competent students through helping them to integrate academic and practical knowledge, and develop creativity in the use of this integrated knowledge, thus aspiring to Bines' post-technocratic approach to professional education. Course 4 (3 year honours) is typical. It emphasises a move away from the medical models of the past. It has three main strands (theory and practice of speech and language therapy, language sciences (linguistics and phonetics) and behavioural sciences (psychology and sociology)) plus, in year 1, biological sciences. The course document however, states that:

> specialist material relating to professional practice runs alongside the study of language and is set in the context of wider psychological and social perspectives offering consideration, at the 'individual' level, of life span development in human interaction and at the 'societal' level of health and welfare settings. (Course 4: 3)

and also stresses the fact that discipline areas do not have clearly defined boundaries but inform each other. In addition:

> the placement and practical elements of the course are acknowledged to be of fundamental importance both to underpin and extend the theoretical learning. (Course 4: 14)

Course 6 also acknowledges the need for SLTs to develop clinical competence through integration and application of subject based and practical learning. This document states that:

> We lay particular emphasis on the linguistic analysis of abnormal communication, for which special skills are required..... The integration of these skills into the array of clinical procedures used by the SLT is achieved

> by approaching each pathological area (e.g. aphasia, stammering, cleft palate) from the complementary viewpoints of the linguist and the clinician (Course 6: 45)

Course 8 takes this further, in adopting a case-based learning approach across the entire course. The course document states learning goals as shown in Table 5.6.

Table 5.6: Learning goals for course 8

Year	Knowledge base	Clinical goals
1	Understand basic concepts	Description: observe, transcribe, report, participate, seek information
2	Integrate information	Analysis: apply theory to assessment, evaluate skills of self and others, use assessment data to plan intervention, implement case management
3	Critical thinking	Integration: integrate previous learning to select appropriate assessment and intervention, plan and implement management, critically evaluate assessment and intervention
4	Creative thinking (generate and justify clinical research)	Professional: novel diagnosis, novel clinical practice, clinically responsible behaviour, awareness of professional and service issues

(Course 8: 15)

The progress from basic understanding to creative thinking and from clinical observer to competent professional is the major focus of each of the course documents surveyed and reflects closely the academic and operational competences outlined by Barnett (1994), while elsewhere in the documentation there are brief glimpses of aspirations to enable students to achieve an education beyond professional competence, that is in line with Barnett's meta-aim of 'life-world becoming'.

Beyond these broad statements of learning approach, course documents also provide detail of the course curriculum itself. Competence is mentioned explicitly in many of the module descriptors, especially those relating to clinical education in its many forms. Here detail begins to emerge of the expected learning outcomes and learning approaches devised to enable competence to develop. Course 1, for example, uses 'observation of live and video taped clinical interaction, role play, group and individual tutorials, seminars, lectures and workshops' (Course 1: 127)

and provided week-by-week outlines of the content and process of delivery of one clinical education module which demonstrated how this worked in practice. Course 12 (Course 12: 75) details clinical placement, seminars, ethics and social policy workshops and independent study as being designed to allow students to consolidate a firm theoretical base for intervention and establish competent clinical and professional skills in year 3. Beyond this, for the purposes of this study, the actual process of learning must be taken on trust. Sitting in on classes might have allowed a different view of how the curriculum is actually delivered, although the presence of an unfamiliar observer would, by their very presence, change the dynamic of the learning situation (Punch, 1998). It might be noted, however, that all SLT courses which have been subject reviewed by QAA have achieved grades in the 'excellent' category, which suggests that their processes and teaching are producing competent SLT graduates.

5.7 Conclusion

SLT education has been firmly established in the higher education sector in the UK for several decades and the broader arguments on the nature and purpose of higher education are important in the education of the student SLT. The tension between Barnett's (1994) operational and academic definitions of competence and his aspiration for a much broader personal outcome of HE are highly relevant to any discussion on developing competence for the students. Even RCSLT states that it:

> seeks evidence that the students' time on the course provides opportunity for their educational development as individuals, rather than the courses being construed as a narrow training exercise (RCSLT 2000: 5)

thus indicating that it values the concepts outlined in Barnett's third approach to HE learning.

The constant tension between academic learning and intellectual stimulation, and the need to have identifiable professional outcomes, however, leads to an uncomfortable juxtaposition of theoretical principles and exhortations for action on a practical level, which is complicated by a diversity of views on what competence on graduation actually means (CSLT, 1994; QAA, 2001). RCSLT guidelines for courses (RCSLT, 2000) make the assumption that a graduate from an accredited course will be competent to practise, and to that end it is stated that:

> for a course to be accredited by RCSLT, its graduates must achieve an acceptable professional standard in speech and language therapy. Graduates recommended for a certificate to practise must successfully undergo a practical assessment of their clinical ability and professional competence. (RCSLT, 2000: 3)

In order to maintain their integrity, SLT courses have to retain a clear view of the academic and professional roles they fulfil and the need to develop both intellectual know-that and practical know-how (Ryle, 1949) which lead to a graduate being identified as competent to practise.

Current course documentation held at RCSLT suggests that there have been major changes in the organisation of the curriculum of SLT students since Stengelhofen and Eastwood wrote. It is clear that course teams acknowledge the necessity for professional competence to be an outcome of both individual modules and the degree programmes themselves. Further, the identification of common super-ordinate concepts of the range of knowledge, skills and professional attitudes required to achieve this outcome relates closely to those identified by van der Gaag & Davies in 1992 and Kamhi in 1995. The difficulty lies in making the transfer from rhetoric to reality. This is explored in the following chapter, where the aspects of practical learning are addressed.

Chapter 6: Competence and clinical placement

6.1 Introduction: the purpose of work-based learning

Work-based learning is part of many degree programmes, as a result of the changing nature of Higher Education since the mid 1960s. Brennan and Little (1996) suggest that work-based learning has three elements: learning *for* work; learning *at* work and learning *through* work. Learning for work includes any learning which is vocationally related, regardless of whether this is delivered through traditional education or other forms of experience. Learning at work relates to training delivered in-house by an employer and therefore matches Bines' (1992) pre-technocratic model. Learning through work includes the integration of knowledge and skills acquired in the process of doing a job, with the application of other job-related learning which may be acquired away from the work-place.

Although these approaches to work-based learning were referring explicitly to employees, Brennan and Little suggest that they can be applied to placements undertaken as a part of HE courses. They agree with Barnett (1994) that even for vocational degrees, Higher Education aims to do both more and less than simply confirm occupational competence. They stress, however, that placements have a role in HE similar to that of laboratory practical experience. They allow practical experimentation to facilitate intellectual development, although without the same level of predictability and controllability as laboratory-based learning. Brennan and Little consider work-based learning to be academically valid in terms of allowing a practical application of knowledge, allowing students to develop work skills and professional attitudes and increasing opportunities for personal development. They outline four approaches to work-based learning as a part of HE, depending on the status of the student and the controls on the curriculum (see Table 6.1).

Each type of work-based learning, however, poses questions about forms of knowledge and how placements can enable students to learn how to learn. If work-based learning is purely to increase the experience of the workplace and employability, then it falls very much into Barnett's (1994) definition of operational competence. If it is structured to enable learners to take control of their own learning at work and through work, then it may well contribute to the development of work-based competence and the higher capacities characteristic of academic competence which would enable the student to use their learning abilities in other fields – one of the so-called transferable skills seen as desirable by HEQC (1997a).

Table 6.1: Types of work-based learning in Higher Education

Type A	Curriculum framework is controlled by the HEI. Work experience is designed with the employer. Learner usually full time student.
Type B	Curriculum framework is controlled by the HEI and professional body. Work experience is designed with the employer. Learner usually full time student.
Type C	Curriculum framework is controlled by the HEI and professional body. Work experience is designed in collaboration with the employer. Learner usually full time employee.
Type D	Curriculum framework is controlled by the HEI and professional body. Work experience is designed primarily with the learner. Learner usually full time employee.

Brennan and Little (1996: 67)

It might be expected that, if anywhere, the work-based aspects of professional education would be the place for a fine-grained description of competencies. As seen in the previous two chapters, however, the numerous approaches to defining competence, together with the complexity of professional activity within the work-place mean that there is plenty of scope for debate about the way in which competence might be facilitated and measured during work-based learning. This chapter explores some of the themes found in the literature on work-based learning and competence within the SLT curriculum.

6.2 Clinical placements in the SLT curriculum

As seen in the previous chapter, the SLT curriculum is designed to enable students to achieve academic, professional and personal development on the road to achieving competence. Practical work-based experience is considered by RCSLT (2000) to be an essential part of the SLT curriculum. It therefore fits directly into Brennan and Little's 'Type B' work-based learning. Brennan and Little suggest that most commonly in this approach, propositional knowledge is acquired in the HEI while process knowledge (Eraut, 1994) is acquired through work-based learning.

Eastwood and her colleagues (CNAA, 1991) interviewed SLT students, clinicians and academics and outlined their views on the purposes of placements for SLT students as being to develop:

1. preparation for employment
2. 'getting through' (passing assessments)
3. professional competence (annotated on the text by McGovern (personal communication) as being 'dismissed in half a sentence!')
4. development of theory-based practice
5. general management skills
6. clinical management skills
7. independent decision-making
8. interpersonal and social skills
9. realistic work experience
10. other benefits of education and health care
11. services partnership
12. commitment to a career in speech therapy
13. clinical skills

To an extent, this list could be grouped into employment-orientated development (1, 3, 6, 9, 12), personal development (2, 3, 4, 5, 7), and professional development (3, 4, 5, 6, 12, 13), all of which are relevant to the development of clinical competence, with items 10 and 11 more relevant to the institutional relationship between HEIs and the work-place. Freeman, Eastwood, Whitehouse and Shute (1996) in an updated publication of the same data, noted different weightings put on different items on the list by each of the

groups of respondents. All valued clinical and general management skills development; students valued opportunities to develop independent decision-making skills and (unsurprisingly) getting through. Clinicians valued the development of professional competence, and also commitment to SLT as a career. Academic staff valued developing interpersonal and social skills and the opportunity to relate theory to practice.

While there is broad agreement on the super-ordinate knowledge, skills and attitudes important for SLT practice (van der Gaag and Davies, 1992a), the majority of SLT literature which considers competence is working on two different levels: firstly the need to identify competence at a given point in time; secondly, the need for competence to encompass new learning and change in each of the aspects of knowledge, skills and attitudes. In work-based learning as part of the curriculum, this tension is exemplified by CSLT (1994), which identified a mismatch between some managers, who wanted new graduates to have enough work experience to be completely 'ready for the job', and others, predominantly academics, who argued for graduates who were theoretically competent and able to continue to learn. It is clear from CSLT (1994) and from Freeman et al.'s (1996) work that the different groups of SLTs had their own biases about the purpose of placements, grounded in their own experience and needs.

6.3 Evaluating clinical learning

Clinical, or work-based, placements are nevertheless seen by many students, clinicians and academic staff as being the most important part of a pre-qualifying degree course in SLT (CNAA, 1991; Parker, 1998). Placements are seen as having 'real-life' relevance. Pletts (1981), for example, saw placements as the point in the curriculum where students relate theory to practice: where discipline-based (propositional) knowledge from the academic curriculum was applied to practical situations, with supervision and guidance to develop practical knowledge. Stengelhofen (1993; 1997) believes that much of what

SLT (and other) clinicians do is, in her terms, academic, in as much as the work involves intellectual engagement and the 'jobs require thought' (1993: 6). As a result, she too is clear that academic and clinical competence must be closely related during placement-based learning and that clinicians' roles lie in providing experiential opportunities for students to learn.

Stengelhofen (1993) related her earlier (1984) model of clinical practice (see Figure 3.1 above) to the role of placements in health care degree courses. She acknowledged the need to identify what a student should be expected to do on placement, but she was also interested in how they learn to understand what they are doing. Her philosophy for work-based learning was that attitude should be 'the driving force for effective practice' (1993: 17). Attitudes are at the deepest level of Stengelhofen's model of professional competence, are the most important aspect of competence, and influence all others. She believed that attitudes to professional practice are developed and demonstrated most powerfully through work-based learning. It is there, for example, she believed that students' awareness could best be raised on their current strengths and limitations of their knowledge, the rapid change and development of the knowledge base, the essential nature of appropriate social behaviour, ethical issues and other aspects of professional life, all of which are part of her definition of competence.

More recently it has been emphasised that clinical experience can have a bi-directional role in developing professional competence: it should not only enable students to apply theory to practice, but should also inform students' further theoretical and academic development. Parker (1998) identifies the role of placement in developing clinical competence as one where not only is theory applied to, but also derived, from practical work. She identifies four types of theory: theory derived from other disciplines; theory of subjects central to professional practice; theory about the knowledge, skills and altitudes required to develop competence (i.e. a theory of practice) and theory of how to acquire these (a theory of learning professional practice). The first two of these,

involving discipline knowledge (of linguistics, behavioural science, biological science and speech pathology), are undisputed throughout the literature (e.g. van der Gaag and Davies, 1992b). Her third and fourth types of theory were, according to Eastwood (1995), not present in SLT work. Parker, however, asserts that much of these last two types of theory do exist but usually only in the form of tacit knowledge. Parker supports Eraut's (1994) view that use of theory in practice not only demonstrates an understanding of that theory but also transforms the learner's theoretical constructs, leading to new theories about practical work.

McAllister (2000) also adopts this bi-directional view of theory and practice. She suggests that clinical placements should promote professional growth in both student and clinical supervisor. Her philosophy of the purpose of clinical education (used as a synonym for placement) is that it should develop an 'interactional professional' (2001: 7) who is able to demonstrate technical competence, professional responsibility and interpersonal competence (the ability to interact with and to change the context of practice). This latter ability, she argues, extends the traditional view of competence to include the capacity to survive and influence change.

Each of the papers listed above emphasises, in its own way, the centrality of experiential work-based learning in the development of clinical and professional competence. While there are differences of emphasis, the elements of learning for work, at work and especially through work (Brennan and Little, 1995) is a common theme.

6.4 Clinical placements and outcomes

There are two difficulties in achieving agreed learning outcomes in SLT placements. Firstly, as seen above, there are many differing beliefs about what competence is at any given point and how this can be defined. Secondly, placements are, by their nature, the least predictable or standardised element of

SLT degree courses. They involve large numbers of individual clinicians, working with disparate client groups, in widely varying environments (Cortazzi, Jin, Wall and Cavendish, 2001) and with access to significantly differing levels of resources. Even if there were to be a single definition of competence in SLT, therefore, there would be diverse approaches to achieving it.

A theme in the SLT literature over many years has been the need to make explicit how students should be enabled to learn on placement, despite the complications involved. Pletts (1981), identified a range of clinicians' beliefs about students on placement, which were likely to influence their approach to student learning. Some had 'the view of the student speech therapist as an unpaid assistant', others expected the student to acquire 'by osmosis and/or magic sufficient therapeutic expertise to pass the searching practical examination at the end of the training', while yet others were intimidated by students, seeing them as 'an academically superior being, who will constantly ask erudite questions designed to reveal the clinician's imagined depths of ignorance' (Pletts, 1981: 132).

Pletts aimed to enable clinicians to become better able to offer a coherent educational experience to students. She identified a need for aims and objectives of clinical education to be written in a form which gives a clear outline of what is expected of both clinician and student on placement and an indication of what are long-term and what are intermediate objectives. So far as she was concerned, the aim of having placement in the curriculum was for the clinician to provide opportunities for a student to move from dependency, through a series of transitional stages with increasing responsibility, to becoming a competent professional graduate who could understand and evaluate her own practice.

Other authors working in the field of clinical education and work-based learning at that time made similar points. Stackhouse and Furnham (1983) emphasised the need for students to become active evaluators of their own performance, while McGovern (McGovern and Davidson, 1982; McGovern ,1985;) used video

in order to enable students to self-evaluate. The philosophy here, too, was that independent learning from placement could be facilitated and that it would ultimately be of long-term benefit to the student and the profession in a way that 'facts' alone could not be.

All of these outcomes are, however, contingent upon knowing what student and graduate competence actually is and how it can be measured in the clinical environment. Pletts (1981), writing at a time when the profession was close to becoming fully graduate entry, suggested that evaluating clinical competence on placement was essential, but becoming less straight forward than when the professional body had had a national curriculum and national examinations. McGovern (McGovern and Wirz, 1981; McGovern and Davidson, 1982; 1983; McGovern, 1985) made an early attempt to increase objectivity in the analysis of clinical competence. She and her colleagues published a series of papers on the development of an assessment protocol and the use of video-recording of students' clinical practice to facilitate clinical learning through student self-appraisal and clinician training. In each of these papers there was an emphasis on three aspects of placement: the student; the client and the clinical environment. McGovern and Davidson (1982) pre-defined categories and attempted to standardise judgements on student performance. They asked clinicians to view video-recordings of students' clinical sessions and make judgements on their performance. They found that when attention was drawn to particular aspects of a session (the content of a session, student therapist and client behaviour, interaction, management of space), the range of comments on a session was both more extensive and more specific than if observers were given no prompts. In using these protocols with students, McGovern and Davidson (1983) found that students' abilities to judge sessions they observed (their perceptions of others' therapeutic performance) were established early, although in a subsequent study, McGovern (1985) found that when observing themselves on video, students' self-critical facilities took longer to develop and she hypothesised (McGovern and Davidson, 1983) that students' actual

performance would develop and change over the entire period of a course as a result of the directed experience on placement.

Stengelhofen (1993) discussed the nature and value of clinical placements, together with the roles and responsibilities of students, clinicians and the services providing placements, in facilitating the development of clinical competence. Her general points, made earlier but in less detail by Pletts and McGovern amongst others, again focus on the need for clear articulation of the nature and purpose of clinical placement, and a recognition of the competing demands on the three groups of 'stakeholders' directly involved in these placements, that is, students, clinicians and academics. An overarching responsibility, shared between both groups of qualified SLTs, is to enable students to learn how to learn. This theme can be traced through the literature on work-based learning in general (e.g. Brennan and Little, 1996) and SLT work-based learning in particular (e.g. McGovern and Davidson, 1983; Morris, 1998).

6.5 Clinical placements and uncertainty

Parker has relied heavily on Stengelhofen's work and also returned to Schon's (1991; 1993) and Kolb's (1984) work to justify her own particular approach to clinical placement learning (Parker, 1998; Parker and Kersner 1998; Parker and Emanuel 2001). She suggests that uncertainty is an intrinsic element of placement and emphasises that the students should not feel the need to get things right first time. Progress towards the goal of competence on placement is not direct, but requires constant minor re-adjustments. These re-adjustments can be made through self-awareness plus the support of supervisors and peers. (Parker, 1998). She is also convinced (Parker and Emanuel, 2001), following Kolb's work, that learning can be cyclical and cumulative.

Uncertainty as presented in Parker's approach to clinical learning is not, however, always welcomed by clinical supervisors themselves. Clinicians can

have pressing responsibilities which may compromise the students' learning opportunities. They have responsibilities to their employer to 'get through' the caseload and accepting students can lead to a lack of predictability as to the amount of client-based work which can be achieved. Indeed, taking students has been shown to reduce departmental productivity (Quinn, 2000) and this is not always appreciated by employers. SLTs also have a primary professional responsibility towards their clients. An issue which has emerged in recent literature, as Morris's work highlights, are the risks involved in clinical placements. Morris's original study (1997; 1998) assumed that SLTs would have an altruistic values base and that this would extend beyond work with clients to the education of student SLTs. Her major and unexpected finding was that clinicians perceived clients as being at risk when their case was managed by someone other than an experienced clinician and they therefore acted to 'protect' their clients. This was especially the case when students were involved. Areas of risk from students were identified by clinicians as: the students' communication skills; the quality and nature of the intervention and the possibility of students making mistakes. Each of these was seen by clinicians as potentially compromising clients' outcomes.

Further research by Morris (2001) explored the concepts of risk in SLT practical placements at a micro-level. Perceived risks to clients and students were found in four areas: psychological; behavioural; medical and structural. Psychological risks of being confused, upset or distressed, for example, were mentioned in relation both to clients and students. Medical risks were identified in relation to physically vulnerable clients (for example, the risk of choking) and behavioural risks of inappropriate therapy, or a student failing to recognise the need to do something different when a session was not working. Structural risks were less easy to define but centred on service delivery and working relationships which might be damaged by a student's presence. Morris did find that the perception of risk and tolerance of risk were issues found difficult by her respondents, although at the same time there was a recognition that a degree of risk is

necessary for a student to be able to learn. Morris's conclusion is that risk management needs to gain a much higher profile:

> the clinical supervisor of today has to adopt a more active and risk-infused orientation to relationships and involvements, if clients are to receive a high quality service and students are given opportunities to learn. (2001: 160)

Without this, the implications for the development of clinical competence in the student are serious. Any approaches to change or extend the opportunities for learning may be greeted with suspicion by the SLT clinicians and placements will continue to be artificially constrained examples of the working environment. If, as suggested by CSLT (1994), graduates are expected to be 'ready for work' and, as stated by McAllister (2000), employees expect graduates to be confident and assertive, able to manage work-place stress, understand and collaborate with other professions, manage changing working conditions, negotiate work conditions and manage time, money and people, students need opportunities to develop these abilities prior to graduation.

6.6 Clinical placements and communication

6.6.1 Communication between clinicians and academics

Student learning on clinical placement is subject to many influences and one of the major themes in the literature over many years has been the need for clinical and academic staff to communicate on a frequent and regular basis to ensure that the clinical curriculum meets the demands of the profession and the employer and that the clinical placements meet the requirements for academic credit. Unexpected findings such as Morris's might otherwise remain silent and different beliefs about the nature of vocational degrees (e.g. Brennan and Little, 1996) may be unexplored, while still contributing to difficult working relationships and impeding the development of students' professional competence.

Over the years many publications (e.g. by Oratio, 1977; Pletts, 1981; Crago and Pickering 1987; Anderson, 1988; Stengelhofen 1993; Fish and Twinn, 1997) have emphasised the necessity for clinical supervisors to have a clear understanding not only of clinical work but also of student learning. While the publications of some of these authors are predominately instruction manuals for supervisors, all stress the need for 'stakeholders' to talk about shared issues, to understand the educational nature of placements and to develop a shared language of competent practice. Authors have advocated a well-structured in-service education to enhance clinicians' abilities to facilitate student learning. This was a major recommendation in Pletts' (1981) paper and it was strongly promoted by Stengelhofen (1993) and the 'Forums on tutoring for experiential learning', facilitated by Stengelhofen (RCSLT,1996b). RCSLT (2000) continued to recommend the need for 'standardised compulsory training in the supervision of students for clinical supervisors be phased in within a continuing professional development (CPD) framework as a way of creating a more empowered clinical community' (2000: 3).

Empowerment of clinicians is also a theme of McAllister's (2000) work. She makes a strong case for changing the vocabulary of clinical supervision. Semantics, she asserts do matter and the term supervisor is limiting if academic and practical learning are to be seen as intimately related to each other. Instead she suggests the term clinical educator as more valid and appropriate. It would remove the concept of 'watching and criticising' and simultaneously express a more valued role for the clinician, thus increasing their commitment to supporting students as they work towards competent practice.

6.6.2 Communication with students

While communication between clinicians and academics is vital in the provision of good placements (Morris, 2001), communication with students themselves is also essential. The better students are prepared for the experience of placements, the better they should be able to use this experience to develop

competence. The majority of SLT courses have pre-placement workshops aimed at preparing students for placement (Parker and Emanuel, 2001) and all clinical supervisors are expected to guide and support students by listening to, as well as informing them (Stengelhofen 1993). Anderson (1988) and McAllister (2000) both stress the need to listen to students, in order to 'foster emancipatory learning' (McAllister, 2000: 5) and enable students to develop confidence in critique and the ability to promote change rather than just comply. McAllister suggests a return to a humanistic framework, which, she believes, characterised earlier approaches to supporting SLT students in work-based learning. It would facilitate personal development in the student, allow for a deepening self-knowledge and, as a result, enable students to discuss and offset anxiety and loss of identity.

> Clinical education, is, or should be an essentially person-focussed process. Knowing oneself as a clinical educator, and in turn helping students to know themselves are key aspects of our work as clinical educators (McAllister, 2000: 6)

Most authors agree that students need the opportunity to explore ideas, discuss and challenge existing practice. Optimally, students should feel comfortable doing this with their clinician, although, because clinicians have a dual role of supporter and assessor of clinical learning (Delaney and Cooper, 2000) they are sometimes concerned that this will show their weaknesses and reduce their final grades. Grundy (1994) and Bruce, Parker and Herbert (2001) both present programmes of peer placement learning, where students are given responsibility, work in pairs and share their ideas with each other as well as with the clinical supervisor which may reduce the threat perceived by students. Cortazzi et al., (2001) describe a strong informal network of narrative, where students' stories of personal experiences on clinical placement helped to share meaning of the experiences, deepen their understanding of clinical work and facilitate further learning, not only for the student but also other students, clients, clinicians and tutors. Communication therefore appears to be as essential for SLT students as for clinicians and academics in the quest for competence.

6.7 Conclusion

Clinical placements have a central role in the education of SLT students and are seen by the majority of authors in the field to be an esential element of pre-qualifying education. There is a diversity of views on the aims of placements which, broadly, can be seen as preparation for employment and professional development. The ways in which placement might achieve these aims has been the subject of considerable discussion. There is, however, a consensus that discipline and process knowledge can develop inter-dependently and students can, as a result, increase their practical and academic competence through placement.

The next three chapters present an empirical study, designed to investigate the views of current SLTs on competence and the way in which placement facilitates the development of competence.

Chapter 7: Competence, clinical education and the views of speech and language therapists: collecting the evidence

7.1 Introduction

Competence for clinical practice is, as has been seen, a key aim for SLT education, and work-based experience as a part of vocational courses may appear to have an obvious and well-understood purpose. A theme throughout all of the literature however is the need for all constituent SLTs (students, clinicians and academics) to develop a shared understanding of the nature of professional competence. Another theme is the differing priorities of each group. In view of this, it appeared important to sample the views of current SLTs in order to learn how they identify competence and what influences their approaches to student learning and helping the student to develop competence in the clinical context.

This chapter outlines the methodology of an empirical qualitative study carried out with SLTs involved in the educational process, which was designed to elicit their views.

7.2 Aims of the study

The study was undertaken in order to explore the views of SLTs about clinical (professional, or work-based) competence. The research questions addressed in this thesis, as indicated in Chapter 1, are:

- to what extent can academic and practical learning lead to a student being judged competent;
- how can practical experience enable the development of clinical (professional) competence;
- how can SLTs achieve a consensus on the nature of competence in the newly graduating SLT?

The first two questions are addressed in the earlier chapters of this thesis. In particular, Chapters 4 and 5 consider the relationship between professional competence and academic learning, through a literature review and analysis of SLT course documentation. Chapter 6 develops the theme of practical learning and discusses SLT literature on the role of practical experience in the development of clinical competence.

The empirical study, while seeking views of SLT respondents on the first two research questions, was intended, as a result of analysing these views and relating them to the literature, to answer the third: how can consensus on the nature of competence be achieved? The aims of the empirical study were, therefore:

- to explore the degree to which the nature of clinical competence could be described by SLTs;
- to explore their perceptions of the relationship between academic and practical learning;
- to identify the extent to which there were shared understandings of how practical experience could enable competence to develop;
- to suggest ways in which consensus on the nature of competence in the newly graduating SLT might be achieved.

The study was designed to include three groups of SLTs: academics; clinicians who supervised students on placement, and students. Academics are involved in the design and delivery of degree courses and may supervise students on placement but they rely on external clinical placements to deliver a major element of student learning. Clinicians, especially those close to educational establishments, are often involved in course design and in the practical preparation of the next generation of their profession. Students have an immediate personal interest in the availability, range and quality of their placements as these influence not only their degree qualification, but also their future professional lives.

7.3 Choice of methodology

As the aim of the study was to elicit SLTs' views about aspects of clinical competence, rather than to measure competence itself, the methodology needed to be grounded in a qualitative rather than a quantitative framework. A number of qualitative approaches were considered.

Some studies on competence have involved observation (e.g. McGovern and Davidson, 1982; Stengelhofen, 1984), where subjects are observed over a specified period of time and their behaviours are recorded as they work. This allows for actual practice rather than reported practice to be analysed. This approach was rejected for the present study on a number of counts. Firstly, the researcher needs to select what is to be observed and there is the potential to overlook important aspects of the clinical situation. Secondly, as indicated earlier, the act of observing, in itself changes what is being observed (Punch, 1998). In the supervisory process there is a complex relationship between supervisor, student and client. Changed behaviours by any individual would be likely also to change the inter-relationship of behaviours. This would reduce the content validity of the method, although measures might be put into place to counteract the problems. Thirdly, specific ethical issues are involved. Permission would be needed from clinician, student and client in order to collect observational data and in particular to video or audio-tape clinical sessions. Gaining freely-given informed consent from clients who have disordered communication is a difficult issue in all aspects of speech and language therapy research. In order to be valid, consent must be given voluntarily, in full understanding of the purpose to which data will be put. This, by definition, is problematic for an individual whose communication is impaired, especially where the individual may also have significant physical, psychological or learning disabilities (Pannbacker, Middleton and Vekovius, 1996). Clients and students may both feel pressured into giving consent because they have a dependent relationship with the clinician or the researcher. Finally, it would have been logistically impossible within the available time-scale to organise

visits to a range of clinics, together with setting up the necessary technical (video-recording) equipment and analysing video-tapes for details of competent performance. Participant observation, too, was rejected as being impractical. In addition to all the considerations listed above, academics normally only supervise students on placement from within their own academic establishment and the author was having a sabbatical from clinical supervision.

Group consultation methods were also ruled out for practical reasons. The Delphi technique (Linstone and Turoff, 1975; Moore, 1987), as used by Davies and van der Gaag (1992a), selects a panel of experts in a field in order to reach a consensus on the field of study. This is an iterative process, where the original items generated are circulated to other experts nominated by the original group, and their comments are integrated into the original list. This cycle continues until consensus is reached. The Nominal Group technique (van der Ven and Delbecq, 1974) speeds up this process by drawing experts together to discuss and agree items while they are together. Neither of these approaches would have been possible without substantial funding and were thus beyond the reach of this study.

A questionnaire survey was seriously considered as an opportunity to achieve a wide sample of responses. The current author has had success in achieving a high response rate to postal questionnaires in previous work (Stansfield 1982; Stansfield and Cheseldine, 1994). These questionnaires were, however, carefully targeted to individuals already known to have an interest in the field of study. Less targeted questionnaires are reported to have a very low return rate, typically 10-30% for postal questionnaires. In order to achieve results which can be analysed, questionnaires need extremely careful design with a decision being made on the level of participation through closed questions (which restrict the respondent's ability to explain their views) or open questions (which may render responses ambiguous or otherwise resistant to analysis). Responses to questionnaires are also difficult to follow up for clarification, as respondents tend to expect this approach to be a one-off rather than a continued interaction with

the researcher (Miller, 1991). A questionnaire therefore might have collected more data, but offered less potential to explore the views of respondents in detail. On a pragmatic basis, a mail shot to all registered SLTs was outwith the budget for this study, while sending a number of questionnaires to SLT managers and HEI staff for circulation was also ruled out: personal contact with managers of SLT services and academics within HE institutions has indicated that the majority of questionnaires they receive are discarded rather than circulated, so questionnaires were unlikely ever to reach the target respondents.

Once a number of possible qualitative approaches had been reviewed, it was decided that semi-structured interviews would be used. Interviews, along with all other approaches to research, have inherent disadvantages which must be overcome. Closed questions will frequently fail to elicit sufficient meaningful responses from interviewees, resulting in restricted data for analysis. Leading questions can skew the responses towards the researcher's pre-conceived views, while rhetorical questions give the questioner the floor and fail to allow the respondent's voice to be heard. Open questions may result in interesting responses, but take the area of discussion far from the intended topic of conversation (Miller, 1991). The ordering and organisation of questions throughout an interview must also be taken into account (Hargie, Saunders and Dickson, 1994). A funnel sequence of questions, beginning with open questions and gradually focussing closed questions on a very specific issue may make a respondent feel trapped into giving answers they do not intend. A question sequence which presents closed and open questions in an erratic order may throw a respondent off-balance and result in responses which lack coherence or focus. A tunnel sequence, usually with a list of closed questions, is useful for situations where large numbers of interviews are to be completed within a minimum time scale, but does not allow for expansion of a respondent's views. Despite these disadvantages, however, it was decided that semi-structured interviews were appropriate for the following reasons:

- They would allow for in-depth discussion within a standard framework;

- They would enable individuals with an interest or stake in the field of clinical education to reflect upon that aspect of their work;
- They would reveal similarities and differences in perceptions about the nature and development of clinical competence in SLT students;
- They would allow probes where ideas appeared unclear to the researcher;
- They would provide examples of the views of current practitioners and students which could be compared to earlier literature on clinical competence;
- They could be organised to fit in with the author's other professional activities and therefore not be a burden to the author or her employer, either financially or through lack of availability for work.

Method

7.4.1 Interview questions

Questions were produced as a basis for a semi-structured interview, to elicit the views of a sample of speech and language therapists involved in clinical education (see Appendix 3). The initial questions were piloted by sending them in written form to SLTs working in two academic institutions which were too far away to be used for face to face interviews. The questions were returned with annotations and comments. At this point it was clear that there were too many questions and that much of the information in the first section of questions was either irrelevant to the main thrust of the investigation or could be gained from course documentation. As a result, the interview schedule was revised by removing the first section in its entirety, focusing the remaining questions and ordering them in a manner suitable for each group of SLTs to be interviewed. Questions were ordered in a wide-inverted-funnel sequence (Hargie et al, 1994), with initial focussed questions and prompts which could be used to elicit further views, while maintaining a common structure and content to the interview procedure. Details of the final interview questions appear in Appendix 3.

7.4.2 Respondents

Three groups of respondents were recruited, these being clinicians who supervise SLT students on placement, SLTs who lecture on university courses leading to a degree in SLT and students studying in the later years of SLT degree courses. All respondents worked or studied in England or Scotland. As is typical of the SLT population, all respondents were female. Table 7.1 gives details of the respondents.

7.4.2.1 Clinicians: Clinicians were recruited in two ways. Managers of services local to SLT courses were contacted informally by telephone, with a follow-up formal request letter and outline question areas (see Appendix 4). This resulted in eight respondents being recruited. In addition, the author approached three managers at an SLT managers' conference, giving them the same literature. As a result two further respondents were recruited.

All clinicians held SLT qualifications. Mean time since qualification was 12 years (range 18 months to 36 years). In total, clinicians worked with students from ten of the fifteen UK institutions where SLT students studied. Mean length of time supervising student placements was 10 years (range 6 months to 32 years). The highest academic qualifications held were BSc (4), BSc Hons (4) and MSc (2).

7.4.2.2 Academics: Four institutions (two in Ireland, one in Wales and one in England) were difficult to access because of distance (two of these had been involved in piloting the questions, as shown above) and the author's own institution was not used. Named individuals in each of the other eleven institutions where SLT students studied were contacted by letter, with an outline of the question areas (see Appendix 4). Positive responses were received from ten institutions and respondents were recruited from eight of these, the remaining volunteers being unavailable to be interviewed within the project's time-scale.

Table 7.1: Details of respondents

Clinicians	Highest Qualification	Length of time qualified	Time supervising students
CL26	BSc Hons	4 years	3.5 years
CL28	BSc	36 years	32 years
CL29	BSc	21 years	17 years
CL35	BSc	9 years	8 years
CL43	MSc	7 years	7 years
CL44	MSc	7 years	6 years
CL92	BSc	17 years	15 years
CL94	BSc Hons	1.5 years	0.5 years
CL96	BSc Hons	7 years	7 years
CL98	BSc Hons	8 years	7 years

Academics	Highest Qualification	Length of time qualified	Time working in HEI
AP1	PhD	29 years	27 years
AP2	MSc	33 years	31 years
AP3	MEd	28 years	25 years
AC4	BSc Hons	14 years	5.5 years
AC5	BSc Hons	14 years	8 years
AC6	PhD	19 years	8 years
AC7	PhD	28 years	20 years
AC8	MPhil	20 years	9 years
AC9	PhD	8 years	2 years
AC10	BSc Hons	11 years	7 years

Students	Previous experience	Course Type	Stage of Course
ST11	School leaver	4 yr Hons	3rd year
ST14	Health care (mature)	4 yr Hons	Final year
ST17	Honours degree (mature)	2 yr Masters	Final year
ST45	Honours degree (mature)	4 yr Hons	Final year
ST47	Business (mature)	3 year Hons	Final year
ST48	School leaver	3 year Hons	Final year
ST49	Gap year after school	3 year Hons	Final year
ST71	School leaver	4 yr Hons	Final year
ST72	Business (mature)	4 yr Hons	Final year
ST91	Business (mature)	4 yr Hons	Final year
ST93	Business (mature)	4 yr Hons	Final year
ST96	School leaver	4 yr Hons	3rd year

All academics held SLT qualifications. Mean time since qualification was 20 years (range 8 to 34 years). Mean length of time employed as an academic was 14 years (range 2 to 32 years). The highest academic qualifications held were BSc Hons (3), Masters (3) and PhD (4).

7.4.2.3 Students: The academics who were to be interviewed were asked if any students would be available at the same time as the author was visiting their University. Subsequently, letters and outline questions for students were sent to six institutions (see Appendix 4) and circulated by the academic staff to students. Twelve students volunteered. Students recruited were in the final or penultimate year of their courses. Three students were studying on three year Honours degree courses, eight on four year Honours degree courses and one on a Masters degree course.

Four students had joined their course as school leavers, and one after a gap year. The others were mature entrants to their course, with a previous undergraduate degree (2) or previous work experience in health care (1) or business (4).

7.4.3 Procedure

Each respondent was interviewed in her own work or study base. All academic staff were interviewed individually. Students and clinicians were offered the option to be interviewed either individually or in groups of two or three in order to offer each other support if desired. Each interview took between one hour and one and a half hours. The total number of interviews is shown in Appendix 5.

The first three interviews with academic respondents were intended to be a pilot for the subsequent interview procedure. These interviews were tape recorded using a Marantz CP430 audio tape recorder with a Realistic PZM external boundary microphone. The Marantz recorder is a sophisticated tool, needing

expert calibration and proved difficult to use quickly and efficiently. As the high quality sound recording it provides was not required for these interviews, all subsequent interviews were recorded using a SONY TCM919 audio tape recorder with the same external microphone. Written notes were also made during each interview. No difficulties were experienced in eliciting opinions from the respondents and no changes were made to the questions, thus the data collected in these interviews is reported together with the results from the other respondents.

Following the interview, each tape was transcribed and typed. Each respondent was sent their own transcription for amendment, approval and permission to use the data. The approval letter is included in Appendix 6.

7.4.4 Ethical issues

Speech and language therapy is a small profession where individuals might be easily identifiable from their stated views. The profession is guided by its own code of ethics (RCSLT, 1996a) which applies to clinical practice, student supervision and research within the field. In terms of this study, the major ethical considerations were lack of coercion, informed consent, anonymity and confidentiality (Pannbacker, et al., 1996; Punch, 1998).

The author, as a senior member of staff in her own institution, had line management responsibility for academic SLTs working in the institution and, as course leader, responsibility for SLT students' progression through their course of study. An immediate decision was therefore made that academic staff and students from this institution would not be interviewed, in order to avoid any feeling of compulsion or dependency. Of the qualified SLT respondents, none had been taught by the author, although two had been educated at the author's institution pre-dating her employment there. Respondents were volunteers, seen in their own working environment.

Respondents received a list of question areas prior to the interviews. All responses were anonymised. Respondents are identified by a letter and number code only. The transcripts removed all reference to named institutions or individuals. Once the audio-tapes had been transcribed, they were stored in a locked cabinet but no further direct reference was made to them. Respondents were free with their comments during the interviews and so, when transcripts were returned to them for validation, they were at liberty to edit them to clarify their views and to remove anything they felt to be incriminating or otherwise sensitive. No transcript was used until the respondent had returned their script and the permission form. All data used in the thesis was taken from the transcripts, as amended and approved by the respondents. No respondent expected a reward, although each received a small acknowledgement (a book token) for their involvement, once the transcript had been returned with permission to use the data.

7.4.5 Validity

The sample of respondents is biased in a number of ways. A large proportion of the SLT population was excluded by geography, as the author could only travel to a limited number of different parts of the country. The study also relied on the availability of SLTs within a constrained time-scale and therefore some interested volunteers could not be included. As the study relied on the goodwill of respondents it is likely that those individuals who did volunteer would be individuals with an existing interest in the area of study, as they committed to spend a substantial period of time being interviewed. The total number of respondents is only a very small sample of the total SLT population in the UK, and their views may be unrepresentative of the profession as a whole. Respondents did, however, take advantage of the opportunity to confirm their own views when reviewing their transcripts. One respondent removed and replaced an entire section (pertaining to a memorable student, whom she felt could have been identified from her description), while four of the students,

seven of the clinicians and all of the academic respondents either added comments to, or corrected some aspect of, their transcript. Thus, while sample biases must be kept in mind, respondents confirmed that the transcripts did accurately reflect their own views. As a result, there is strong internal validity, even if the nature of the sample reduces external validity.

7.5 Analysis

7.5.1 Transcript returns

All academics and clinicians and nine of the students returned their annotated transcripts within two weeks of their being posted out, together with permission to use the data. The remaining three students responded to a reminder letter sent four weeks after the original transcript had been mailed. As a result annotated transcripts for all thirty two respondents were available for analysis. A sample transcript from each of the groups of respondents appears in Appendix 7.

7.5.2 Choice of method of analysis

In this study, differences existed between respondents, for example, in the place where they studied, the time since qualification, length of time in post (or on a university course). Experience of the student supervisory process and personal experiences throughout their professional lives, are likely to have created differing views and perceptions of the issues discussed. The analysis of the data presented here used the final edited transcripts exclusively, in order to allow the respondents' voices to be heard as they chose for themselves. Individual responses were considered within the context of the respondent's overall 'stance' rather than using a surface content analysis. The need for consideration of the broad picture is demonstrated in the following examples in which students describe memorable supervisors. Out of context, the comments:

'the therapist was ..... efficient' (ST17)
and
'she kept a really good diary and all the other paperwork' (ST97)

might suggest similar characteristics in the two supervising clinicians being described, but in context the picture is very different:

'the therapist appeared not to want a student.....the role of the student and therapist was never made clear....the therapist was aloof, and unapproachable and efficient' (ST17)

suggests a much less happy learning situation than:

'always available to give help if I needed it.....brilliantly organised.....she'd show me how she kept a really good diary and all the other paperwork' (ST97)

Data analysis has been subject to a number of theoretical influences. Grounded Theory (Glaser and Strauss, 1967; 1968), coming from a sociology tradition, allows inductive reasoning or theory building from the phemonena it represents. Text is allowed to speak through the identification of concepts, themes and understandings which are evident in the material under consideration. Glaser (1992) and Strauss (Strauss and Corbin, 1998), have diverged to some extent in their descriptions of Grounded Theory since their initial work together. Strauss and Corbin now advocate an approach where data analysis follows a standard format. Firstly, in 'open coding', information is categorised and 'properties' or subcategories and their 'dimensions' are identified. Next, in 'axial coding', the data is re-assembled using a logic diagram where the central concepts (central phemonena), influencing conditions ('causal conditions'), actions ('strategies') and outcomes ('consequences') resulting from these concepts are presented by the researcher. Following this, 'selective coding' is

used to develop hypotheses ('conditional propositions') about what the data is saying. There is a rarely used final stage, in which the researcher may embed the findings from their study into the broader social, historical or economic environment (Cresswell, 1998). Glaser (1992) suggests that this approach is over-technical, with too much attention being paid to a hierarchy of analysis, while, in his own view, constant comparison of data can successfully allow categories to emerge.

In the current work, concepts and themes have emerged through open coding of responses from each individual and group of respondents. Emerging themes were generated and then grouped. Subsequently, the themes and concepts which emerged were compared within and across individuals and groups of respondents and within and across questions in order to reach an understanding of the respondents' views. At times these views were easily articulated and identified, in others they emerged only indirectly through examples offered by respondents in response to questions, or occasionally through unusual juxtaposition of words, or non-verbal communication such as long pauses or tone of voice, which were noted on the text to aid recognition. Throughout the analysis the author attempted to identify the central concepts, influencing conditions, actions and outcomes resulting from these and develop hypotheses about the nature of competence, as perceived by SLT respondents while trying, as far as possible, to maintain a distance from her own preconceptions. The analysis, while influenced both by Glaser and by Strauss, owes most to Glaser's (1992) version of Grounded Theory.

Qualitative research does, however, always involve an element of interpretation by the researcher and Geertz (1975) speaks of 'thick description' being used to interpret sociological observations and data. He asserts that in ethnographic research, what is presented as data is really the writer's own construction of other peoples' constructions. This ability to produce 'thick' description relies on the ethnographer's ability to observe and describe, but also to apply interpretative insights to the data being observed and described. Geertz's work

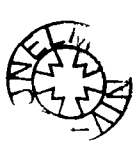
in social anthropology suggests that a surface 'thin' description is virtually impossible to write and is insufficient to draw out different levels of meaning from sociological data. Instead, he suggests that ethnographical studies produce a 'stratified hierarchy of meaningful structures' where behaviours are 'produced, perceived and interpreted...' (1975: 7). He gives as examples, the interpretation of meaning from the rapid closing and opening of an eye as potentially being an involuntary twitch, a wink, or a burlesque 'fake' wink, dependent upon the context and the intention of the winker. This necessitates an ability in the observer to understand the intention of the actor (in this case the person who winks) in his or her cultural context.

'Thick description' has a bearing on the current work as it aims to develop the ability to understand the person's intentions and understandings. To some extent, in the analysis of the data here, the author is lucky to share the same professional background as the respondents. It might therefore be expected that there would be some shared knowledge, experience and understanding of a range of issues pertaining to this professional identity. The danger is of over-interpreting the data: of assuming joint understandings which do not, in fact, exist. This work, while not involving ethnographic study in the true sense of observations, still relies on data screened through the perceptions of the author with the consequent potential for errors of omission and commission, bias and misinterpretation.

7.7 Conclusion

In summary then, a number of approaches to eliciting SLTs' approaches to developing clinical competence were considered. It was decided that using semi-structured interviews would have the benefit of allowing an in-depth exploration of ideas and motivations from a number of students, clinicians and academics. Questions were critiqued by colleagues who would not be involved in the main study and an interview protocol was designed and carried out with an opportunistically recruited sample of SLTs. Transcripts were analysed only

after respondents had had the opportunity to edit and validate them. Super-ordinate themes were generated from the data using a Grounded Theory approach to the development of constructs and Thick Description was used to extract meaning from these constructs. A summary of these constructs and illustrative examples appear in the following two chapters.



Chapter 8: Reporting the views of SLTs I: identification of competence

8.1 Introduction

The major focus of the semi-structured interviews was the clinical component of the degree courses and how SLTs viewed this in the context of developing competence in SLT students. Other questions and probes were used to support the central interest and to attempt to identify the ways in which competence was viewed by the respondents.

Clinicians and academics specialised with different SLT client groups. Unlike van der Gaag and Davies' (1992a) findings, however, while clinical speciality was mentioned in examples given by respondents this did not appear to influence their responses. This is probably because the focus of the interviews was not on SLT specialism, but on developing clinical competence in students. Analysis of the respondents' transcripts allowed a number of themes to emerge. This chapter focuses on how competence is defined, while Chapter 9 focuses on the role of practical placement in the development of competence.

Initially, the definitions of competence appeared to follow the traditional divisions of knowledge, skills and personal characteristics, attitudes and attributes, but there were several layers within these concepts as shown in Figure 8.1

Figure 8.1: Aspects of SLT competence

Clinical knowledge	**Clinical skill**	**Personal characteristics**
Theory for practice	Techniques and competencies	Desirable personal characteristics
Theory in practice		People skills
	Flexibility	
Knowledgeable skill		
		Learnability

All three super-ordinate aspects of competence were seen to be inter-related in complex ways, rather than having rigid boundaries. This chapter explores the

ways in which respondents identified the nature of competence in SLT and explores how the different aspects of competence are seen to relate to each other.

8.2 Competence and clinical knowledge

8.2.1 Theory for practice

Clinical knowledge was a core concept of clinical competence for all respondents. This knowledge was seen as including discipline knowledge, but not being synonymous with it. Instead, respondents displayed a broader and more holistic and integrative concept of knowledge. Theory from all the discipline areas identified by RCSLT (2000) was identified as continuing to be essential for SLTs, for example 'speech pathology, phonetics, linguistics, anatomy, audiology, etc.' (AP2); 'things like using neurology to think about localisation of brain pathology' (CL98). Students, in particular, mentioned specific aspects of discipline knowledge in their outline of competence, for example 'underlying speech theory – knowledge of disorders is needed' (ST19); 'lectures in aphasia' (ST17); 'the PALPA[1] model' (ST48); 'the Bloom and Lahey[2] model' (ST47); 'auditory processing has supported lectures on audiology and hearing' (ST11). All of these are aspects of study within the disciplines of linguistics, psychology, biological sciences and/or speech pathology.

Probably because of the shared professional background of the interviewer and respondents, there was no detailed description of these areas but there was consensus that, in the words of one clinician:

> You need a knowledge base. A basic level of knowledge in a wide range of areas, which you can refine, depending upon what the job is going to be. (CL94)

Several students had commenced their courses expecting answers:

[1] A cognitive neuro-psychology approach to describing language breakdown following a stroke.
[2] An approach to describing child language development.

> We all come to university thinking we are going to learn 'the truth'. (ST91)

> When I started the course I thought it would tell me what goes wrong, and this is what you do to put it right. I now realise that this was naïve. (ST72)

There was, however, a strong consensus that discipline knowledge cannot be 'learned' and then 'known for ever', but rather, as theory moves forward, there is a need for the clinician to continue to learn and apply new theories. Possibly as a result, there was a large amount of reference to models and frameworks to aid understanding of particular communication disorders. Respondents encapsulated this by saying:

> The first thing you have to learn is that everything is an ideal, a way of looking at things, a model.... if you stick to one it's not going to work. (ST91)

> Theory is the core knowledge about a subject. e.g. a specific disorder, a process of development, a way of analysing a problem (a framework). (CL43)

Models and frameworks were seen by academics as being useful structures within which clinical knowledge could develop, as indicated by AC9: 'students learn about frameworks for assessment and frameworks for intervention'. Some academics referred directly to similar theoretical frameworks as the students, in particular cognitive neuro-psychological models (which are core components of teaching on aphasia) and models of child development, necessary for work with developmental speech and language disorders. Academics also explicitly mentioned models of learning drawn from the educational literature and described how teaching was structured to enable students to understand their personal approaches to learning as well as to ground the theoretical aspects of their course. Kolb's (1984) learning cycle (AC8); problem-based learning (AC9) and case-based learning (all academic respondents) were approaches described although this level of abstraction was sometimes found by students to make learning difficult, despite the best intentions of academics.

Students made strong pleas for the relevance of discipline-based knowledge to clinical work to be made explicit. They could see the point of studying aspects of their course, for example ST11 was aware that she needed linguistic theory, but said 'it is only when you get to speech pathology lectures that it starts to be related to communication disorders'. Understanding the clinical relevance of theory was increased, according to students and academic respondents, by guest lectures from practising clinicians, who related theory directly to their own practice.

For all respondents, discipline knowledge was seen to be a necessary element of competence, but in the context of these interviews, there was no indication that respondents valued discipline knowledge purely for its own sake. It was only when it was applied in the clinical situation that its relevance, and therefore value, as a part of competence was acknowledged.

8.2.2 Theory in practice

Beyond the existence of discipline knowledge, there was a recognition of the need to use this knowledge in practice, giving rise to another form of clinical 'knowing'. Theory and practice were seen by all respondents as being interacting key elements of competence, with practice enabling theory to come to life, but also to allow further theory to be generated. The first part of this concept is exemplified by a number of respondents:

> There is a learning spiral and they [students] keep returning to things. They will do some theory, then practice on placement, then return to the theory. (AC8)

> [competence is] a combination of theory and practical knowledge. (ST45)

> As well as the knowledge in your head, there is also the skill to know how to access information if you don't know. It's how you use your knowledge and how you are as a person with that knowledge that make you a competent therapist. (CL94)

The development of theory from practice was mentioned by a number of respondents. Students tended to see their own theories developing as a part of clinical learning:

> You need time to learn the theory but also practice in doing therapy and at the same time noting what is happening and revising ideas and hypotheses later. (ST91)

> After my last placement I think I have got a theory of my own therapy. Until I was asked why I had done things I was really unaware of it.... The therapist asked me what I got from that [session] – and she drew up this big chart of things – and I thought, 'wow, I observed all that!' I'd been far more organised about it than I thought I was. (ST97)

Clinical theorising was described explicitly by some academic respondents, possibly because of their need to relate their clinical thinking to formal lecturing. AC8 and AP1, for example, described their principles of decision-making as establishing hypotheses, testing these and involving the client in the decision-making process:

> I make a number of hypotheses as soon as I meet the client, then watch the behaviours to modify these hypotheses..... I am also very interested in the client's own perception of the problem and their needs..... You also need to look at what the client wants and look at the environment and see the person in context (AC8)

> Asking the client what they think. Asking self if intervention is of practical value to the clients. (AP1)

Clinicians initially appeared to see theory as research- or discipline-based. They were, however, discriminating in their evaluation of theory and in exploring the theories used in clinical work, many of the clinicians did identify ways in which they developed their own approaches, even if they were cautious about referring to these as theories.

> In therapy you have people talking about convoluted theories, but when you ask them what they would do, they say just what you would do yourself. It's linking theory that is important in working out what is going on with a child. (CL94)

> You should always be thinking to yourself, to develop your own knowledge. It is much more interesting that way. You wouldn't just take a theory and apply it blindly (CL35)

Each group of respondents described how they used discipline knowledge, theoretical models and frameworks and their own experience, to theorise about their work. Students and academic respondents appeared most comfortable with the vocabulary of hypothesis testing, but in their own ways the clinicians also demonstrated a firmly grounded understanding of how they developed their personal theories of practice.

8.2.3 A summary of views on clinical knowledge

In summary, as in Kahmi's (1995) work, discipline knowledge was regarded as a 'given' to a large extent, with emphasis being placed on its relevance to the clinical situation and its applicability to particular clients or client groups. Beyond this, respondents had a clear view of how their personal knowledge base included a knowledge of the process of therapy and individual constructs of clinical work, built upon their personal interpretations of both discipline and process knowledge. Clinical knowledge was, therefore, seen as a complex construct, comprising theory for, and theory in practice.

8.3 Clinical skill

8.3.1 Techniques and competencies

There was a high level of consensus on the basic skills required by SLTs, although without context, these could easily be said to apply to almost any occupation involving work with people.

While direct questions about clinical competence elicited the list of skills (see Table 8.1), clinical skills were seen by respondents as being more complex than a straightforward list of 'can-do' technical activities and the list which was generated in the course of the interviews was heavily contextualised.

Table 8.1: Skills identified as necessary for competent practice in SLT

Ability to:	Collect data
	Analyse data
	Problem solve
	Seek information
	Use knowledge
	Relate to people (especially clients) appropriately
	Assess client's overall needs
	Prepare for sessions
	Use that preparation during sessions
	Judge accurately how to proceed
	Make onward referrals
	Write well
	Be flexible
	Think on their feet
	Cope with new situations
	Incorporate new learning
	Do clinical research

When asked about their own clinical decision-making, respondents did describe techniques they used during their work to exemplify clinical skill, but no respondent equated clinical skill directly with technique. Narrative from one student helped to identify the role of technical skills in the overall context of skilled clinical action:

> I was able to run the Reynell[3] comprehension section, just after we had had lectures on how to do it. You tend to remember things like non-contingent praise[4]. I found it really useful. I was petrified when I started doing it, as I was warned the child wouldn't co-operate. It was a big relief when he actually did it. I thought 'Oh, I can do this'; put the equipment out; I can record the answers; I can score it. It really built up my confidence..... To a certain extent it was intuitive, ... talking to children anyway, but we had actually had the lectures on the type of praise to use and they way to encourage children, so it was making sure that everything I said was along the same lines. I think I had the technical skills to do the test. (ST11)

Technical skills, like the clinical knowledge base, were largely assumed by qualified respondents. CL35, for example, spoke in passing of:

[3] The Reynell Developmental Language Scales are assessments designed to measure the understanding and expression of spoken language in children aged between 1 and 7 years.
[4] Praising the child for effort, rather than success on a task.

> Thinking about what goes into a particular process. For example in a laryngectomy[5] case, if someone has a valve fitted as a secondary procedure, what should be involved in that in a normal case. (CL35)

The technique of valve fitting itself, however, was a 'given' in the context of a broader concept of clinical skill in working with this client group.

'Competencies' were mentioned by many of the respondents in relation to clinical skills. Several referred to course or clinic literature which had been prepared to identify 'competencies' in students and the way in which these had been teased out, in order to specify skilled clinical action. Some respondents appeared to feel confident that this paper-work was comprehensive and sufficient to measure competence in the clinic. CL96, for example, provided a departmental placement pack which listed the expectations of students while on that placement, required students to self-assess and identify the competencies they wished to develop on the placement and related this directly to the demands of the local university, with whom it had been jointly produced. AP2 referred to tutorial forms which again listed what skills students needed to demonstrate to be considered competent, and ST48 spoke of their clinic handbook listing 'core skills - people skills, listening skills, being organised and prepared - we have about three pages of these'. Some students appeared to have a view of skilled clinical action as a challenging goal. ST71 stated that 'on a personal level, you need to have personal skills up to scratch', implying an absolute measurable level of interpersonal skill, while ST11 was clear that 'flexibility is important, but also competence is about being right'. CL98 believed that the NVQ model may be a potential improvement in the way in which competence could be quantified:

> It would be up to the university and the student to set up a portfolio of evidence for the four years, which would demonstrate that students had achieved all the target competencies. Employers would be very interested in that. It would be useful for recruitment (CL98).

[5] Laryngectomy involves removal of the larynx (voice box) usually as a result of cancer. A valve may be inserted in order to protect the airway from infection, and to allow the person to have a 'voice'.

Other respondents were less sure that techniques and measurable competencies were synonymous with clinical skill. On the whole, these were seen as being necessary, but not sufficient for skilled practice. Several respondents echoed AP3 when she said, in discussing skilled clinical action, that 'Overall, competence is more than just the sum of the parts. It is not just a list of the parts'.

8.3.2 Skill and flexibility

While all the skill areas listed in Table 8.1 were considered to be necessary for competent clinical performance, an essential component mentioned by every respondent was flexibility. It was identified as underpinning every successful session and its absence was usually seen to be a part, if not all, of the cause of unsuccessful ones. Students described being taught to build flexibility into their sessions before this became embedded in their practice. ST45, for example, said 'As part of our placement preparation in our session plan we are encouraged to plan an easier and a harder task for each goal in case we need to adjust an activity'. Another reported finding it difficult to be flexible enough to make rapid decisions during a session. ' It is difficult to think "on the hoof". I think this will speed up with practice. It is a result of lack of practice and confidence' (ST72). Other students described situations where they had needed to be flexible, together with the reasons why this was more or less easy. Narratives from two students exemplify this:

> [a] child with special needs. I was going to do the 2 Word Toy Test[6] with him. I knew his attention was not very good. I had walked from his classroom with him into the room where I was going to work. I had already decided I would work on the floor rather than at the table. I knew the clinician was going to be in the room with me. I'd been talking to the child on the way to the room about his cold hands. I said this to the clinician as I walked into the room to make sure he knew it was OK for both of us to be there. She said 'don't interact with me, you are interacting with him'. So that made me feel very uncomfortable and nervous. She made it obvious that she was observing. I was very conscious of her being there, not in control, didn't really know the test. I couldn't keep his attention, partly because of his attention difficulties, so I was: trying to read the test; have the right materials; say the right things

[6] Assessment of language skills

> exactly; keep his attention (e.g. stopping him taking shoes and socks off) - and I was told I was 'in his face' and too close.
>
> I was very upset about it afterwards. I was completely out of control and the difference was – I think, confidence. You are so conscious of doing the test and being observed, you don't observe what the child is doing as much as you should. (ST14)

> It is hard not to be rigid. I had a session where a client broke down in tears. At first I though 'oh no, I've got all this work to get through'. It was a single session evaluation [degree practical assessment] and it was important to me, because there was a viva afterwards. Then I just thought – no, I was there for that person so I needed to step back and look at what was going on and be in tune with that time, and adapt to suit them and forget your plan. What is important for that person at that time might not be their word-finding or whatever. This lady was telling me about what had happened to her in the past. We went with that and then discussed what she wanted to do after she had disclosed her feelings. That was what she needed. (ST48)

In these sessions, students required technical skills, but in addition flexibility was needed because of the potential, or actual behaviour of the client, although the situation, lack of planning time, or limited experience made flexibility difficult.

8.3.3 Knowledgeable clinical skill

When discussing skilled clinical work, clinicians and academics tended to describe principles of intervention, rather than actual events, but most appeared to possess deep-seated clinical knowledge when they described how they planned and then changed their own sessions. Again, narrative from one clinician gives an example of this:

> In the waiting room I am looking at what they [child] look like: physical skills; how they are interacting with mum; what they are like when they come through to the [therapy] room. These give a really good starting point for the rest of my session. It varies from child to child and depending on the mum. This mum didn't want anything to do with me and was sitting on the other side of the room.
>
> I started with formal assessment first, then informal, and then I chatted to mum at the end, who was still sitting clearly not wanting to be there. I tried to check that what I saw of the child that day was typical and tried to clarify my thoughts. The more experience I have had, the quicker I make

> decisions. In this case it was clear the child was language delayed across the board, so I decided to put her in an early language group and let the mum know that.
>
> I have a checklist in my head in order of sections I want to look at – pre-linguistics or language, depending on the age of the child. I want an answer in my head before I let them go at the end of the session. If not, I want to see them again for a follow-up session. (CL26)

At first clinicians and academics variously described their decisions on how to conduct sessions as on-the-spot decision-making, gut instinct, or intuition. CL35 was typical when she said 'My instinct is that there probably is some intuition, but I can't quantify or measure this'. Intuition was not, however, seen to be a major part of skilled clinical decision-making once respondents reflected on this. 'Gut feelings are probably based on experience. Similarly ESP [extra-sensory perception] I think is a part of a great deal of perception and some experience put together' (ST72). The majority of qualified SLTs, while acknowledging that on-line decision-making was difficult to articulate, identified the importance of having learned from previous mistakes and an increasing ability to notice things and integrate them into their existing knowledge base as core aspects of competent practice. It was clear from respondents that knowledge and skill were not seen in isolation, even when they spoke of the needs for 'basic knowledge and the core skills' (ST49). Templates of previous clients (depending on the length of experience of the clinician) were complemented by such things as local sociological knowledge (for example the typical performance on standardised assessments in given areas of a city) and by theoretical underpinnings (e.g. ages and stages of development; theories of approach to different communication disorders). Most respondents agreed with CL26 when she said:

> you start thinking it is all intuition but forget there is a theory behind it all and you have forgotten what you have learned and where you are coming from. (CL26)

An appropriate theoretical background was something which was seen as essential to skilled clinical practice.

8.3.5 A summary of views on clinical skill

In summary, clinical skill was seen to include individual skills and techniques, but these were not the whole picture. Flexibility was seen as a core aspect of skilled practice, and this itself varied, depending upon therapists' levels of clinical knowledge and their personal confidence in the clinical situation. Clinical skill appears to be seen to involve a level of practical judgement: the ability to use knowledge and techniques and to adjust them to the situation as it is appropriate and necessary. Clinical knowledge was seen to enable therapists to become increasingly flexible in their ability to use this practical judgement, reflecting the literature on the development of expertise (Dreyfus and Dreyfus, 1986 ; Glaser and Chi, 1988; Roulstone, 2001). Clinical skill therefore is a second area of complexity in the construction of competence.

8.4 Competence and personal characteristics

8.4.1 Desirable and undesirable characteristics

All respondents were clear that in order to be competent, an SLT had to be a 'people person' (CL92) and that the profession appeared to attract individuals with a basic interest in people. An initial list of personal characteristics considered necessary for competent practice was generated relatively easily (see Table 8.2).

Table 8.2: Personal characteristics and competence

Desirable		Undesirable
Good communicator	Enthusiastic	Poor communicator
Pleasant	Motivated	Uncaring
Warm	Positive	Disinterested
Supportive	Flexible	Cynical
Able to instill confidence	Curious (interested in learning)	Patronising
Empathetic	Insightful	Aloof
Able to read situations accurately	Having a good self-knowledge	Unapproachable
	Conscientious	Critical without offering support
Genuinely interested in the clients/ students	Having integrity	
	Reliable	Lacking confidence
Sensitive to clients' needs	Honest	Disorganised
Accepting of clients' views	Patient	Lazy
Considerate	Professional	
Encouraging		

As with the skills listed earlier, the majority of these 'desirable' characteristics might be expected to be found in many aspects of work which involved people. All were mentioned by a number of respondents, with the key characteristics identified by the majority as being enthusiasm and motivation. From these, other characteristics appeared to follow. One student spoke of a clinician who 'was really motivated herself. She really loved her work. I would like to be like her' (ST48). Another, while listing many positive aspects of a clinician, said 'and especially she was enthusiastic' (ST72). Clinicians and academics, similarly, spoke of good students as being, for example, 'interested, aware, motivated' (CL35) while one clinician, recalling a memorable supervisor when she had been a student herself, said:

> She had a passion and tried to encourage me. I thought I wanted to be like her, with her enthusiasm. (CL29)

The fact that some characteristics were seen as undesirable did not, however, exclude them from being met by respondents in the course of their work. Students in particular, mentioned clinical situations where they thought the clinician had demonstrated undesirable characteristics:

> [the clinician] fired tasks at the child without asking the mum any questions about what she thought the problem was, or explaining what she was doing. I did not feel comfortable with that. She appeared not to be interested in the client. (ST49)

> [a clinician] I had would talk about all the things the client could not do while they were present. It is rude and unprofessional. I felt very uncomfortable as a student, but I could not say anything because of the student's role - and the clinician would be assessing you at the end of the placement. (ST47)

> The worst thing is being told you are going to do something, preparing for it and then the clinician being so disorganised that there is no opportunity to do it – every week! (ST17)

Clinicians and academics were also able to give examples of 'undesirable' characteristics in students. AP2 spoke of a student who 'thought turning up

alone was [in itself] sufficient'. A longer extract exemplifies other difficulties identified by several clinicians:

> .... could tell from the first meeting it would be difficult. Lack of enthusiasm. In the induction to the placement she said immediately that she didn't like working with children (this was a paediatric placement). Not good with children or parents. All the clinicians involved in the placement felt she had problems with interaction and communication – which was a big problem. She couldn't get involved in group discussions in the staff room and we are a friendly department. It was nearly impossible to get her to interact. Her manner always seemed as if we were criticising and we looked at our own behaviour but decided we were being very supportive..... For her practical exam she didn't even get the room ready in time for the exam – one of the therapists ended up doing it for her. I felt very anxious about leaving the child with her for the exam. She did fail..... (CL92)

The major concern for all respondents who described undesirable characteristics was an inability of the person concerned to communicate appropriately. This was variously described as 'couldn't interact with the patient' (CL96); 'eye contact was abysmal, social skills were abysmal' (CL98); 'difficulties in making self understood by clients or carers' (AP1). The ability to read a situation and communicate appropriately in it was seen to be a core requirement of a competent SLT.

As can be seen, a number of the personal characteristics listed above had been identified earlier as skills, and the overlap in concepts of skill and personal characteristics was also evident when many respondents spoke of 'people skills' and 'interpersonal skills', which were thought to be deeper-seated than the techniques and competencies which were also being identified as skills. Such 'people skills' all appeared to be grounded in an attitude towards people, variously described as maintaining the client's dignity, avoiding a patronising manner and valuing people, or 'unconditional positive regard' (ST48): being a 'people person' (CL92).

The identification of desirable and undesirable personal characteristics listed in Table 8.2 was the beginning, but not the end of the story, as could be seen when respondents were asked to describe their most memorable clinician or

student. About half of the memorable individuals were highly commended, while the other half were criticised in strong terms. All the descriptions focussed mainly on the attitudes and attributes of the person in question, rather than what they knew or could do. It was not, however, just presence or absence of these characteristics but also their amount and intensity. The qualifying vocabulary used by respondents demonstrated the strength of feeling underlying these responses.

Students spoke of positive experience of clinicians with 'a genuine interest in the person.... A very good listener.... An excellent role model' (ST14); 'the one who stands out was really motivated herself' (ST48); 'she gave brilliant feedback...'(ST97). Negative experience was also emphatically described: '*so* disorganised' (ST17); 'rude and unprofessional' (ST47); 'aloof, unapproachable' (ST71). Clinicians similarly saw intensity as being an issue. Memorable students were 'very interested... they bring a joy and enthusiasm' (CL29); 'very lively... bright and bubbly... would be good at whatever she did' (CL44). As with students, clinicians' and academics' negative experience was also a matter of degree:

> A problem student. Partly it was personality, but also the amount she asked of the clinician and the *way* she asked - demanding support. She was *constantly* there asking questions....but she completely ignored the answers she was given... eventually she [was] felt to be a nuisance (CL26)

> Difficult student – no insight and very little initiative or interest shown... wouldn't or couldn't ask questions. She seemed to have no motivation.... Always came back with an excuse. (CL43)

Other respondents spoke of consideration which bordered on obsequiousness, enthusiasm and motivation which became intrusive over time, and an interest in learning which led to an over-demanding approach to the clinical supervisor. As a result, it is clear that students have a fine line to tread. They are expected to be enthusiastic but not too enthusiastic, pro-active but not pushy, assertive but not aggressive, knowledgeable but not a know-all, and confident and flexible (but not over-confident or over-flexible). In this context, it is easy to see that

learning to judge the nuances of clinical behaviour is a challenging task and one which does not easily lend itself to clear guidelines or measurement.

8.4.2 Personal characteristics: innate or learnable?

There was a range of views on whether personal characteristics were innate attributes, or attitudes which could be learned and developed. Some respondents described clinicians and students whose overall manner was seen as positive:

> Excellent clinician – she was very knowledgeable, keen to answer questions, and to encourage me to learn. It was as if she was inside my mind – knew what I wanted to learn and she gave it to me. (ST45)

> Very enthusiastic, with good interpersonal skills. I was working with adult acquired clients and with young people with progressive neurological disorders – the students worked with me with the adults. They were empathetic – the kind you could bring into anyone's living room. (CL29)

Unlike skill, when respondents spoke of enthusiasm, flexibility, or empathy, for example, there was a view that these characteristics were not purely related to specific contexts, but were 'of the person' in a broader sense. Thus, there did appear to be a view that a person's overall approach to life would colour their approach to work and influence their ability to be a competent clinician. When asked if a therapist was 'born or made', the majority of respondents suggested that some personal characteristics were innate character traits but they were vague on which these might be. AP1, for example suggested that 'the caring/ empathy dimension which is essential to the therapist... I suspect is born not made', however the majority simply made statements such as 'Personality needs to be the right sort. So a therapist is born to an extent. Some of it is inside you' (ST93) or 'the people person is born... you are either that way inclined or you are not' (CL94). There was, therefore an initial concept of aptitude for SLT work.

Once this was teased out a little, however, there was agreement that while some students found it easier than others, much of the attitude and value base

of the profession could be learned by students, given an appropriate level of support and an appropriate personal attitude to learning:

> There is a personality type which lends itself to these types of employment, but it is dangerous to say that it is born and not made. It is too arrogant. There are some people it comes more naturally to than others (CL35)

Academic respondents did express concern about selecting students for courses and were willing to accept that was an inexact science, particularly in relation to personal characteristics. A number of responses exemplify this concern. 'The selection process picks out the ones we *think* are born' (AC6); 'less good at spotting potential in people from the wider range of social backgrounds we want to recruit, as we have less experience'(AC5). In general respondents agreed that the attitude and values base of the profession could be learned, even though there probably were personal attributes which predisposed a person towards success in the profession. In light of the discussion above, however, AC10, took the strongest line in that she believed that 'Anyone can be taught..... I don't think there is a particular 'breed'.

8.4.3 Summary of views on competence and personal characteristics

Personal characteristics were viewed by respondents as a core component of clinical competence. The majority of characteristics deemed to be desirable were 'gentle' (van der Gaag and Davies, 1992b), people based attitudes, values and attributes of which enthusiasm and motivation appeared to be the most highly valued by respondents.

Presence of particular personal characteristics was, however, only one of the considerations of respondents and a further theme was the amount and intensity with which personal characteristics were demonstrated by students and clinicians. Respondents outlined the boundaries and parameters within which attitudes, values and attributes appeared to enhance or reduce clinical competence.

There was agreement that there were some basic character traits which pre-disposed people to become competent SLTs, although no respondent was able to specify these exactly, and indeed, it was acknowledged that there may be a change in the characteristics which were desirable as the work of profession changed. It was also agreed by the majority of respondents that it was the way personal characteristics were applied in the work situation which led to a judgement of competence. After discussion, most respondents agreed that the majority of attitudes and values desirable for competent clinical practice were not innate and could be learned, although without the ability to value people, communicate well and be empathetic, other aspects of clinical competence would be unlikely to develop. Learnability was seen to depend upon students' experiences and clinicians' approaches to the learning environment in clinic. Learning to acquire the attitudes and values of competent SLT practice was thus recognised as being far less tangible than learning how to acquire knowledge and skill, while being closely related to these aspects of competence.

8.5 Conclusion

Respondents' views on clinical competence appeared at first to fall into the relatively traditional subcategories of knowledge, skills and personal characteristics (attributes, values and attitudes) identified by previous authors from Stengelhofen (1984) to van der Gaag and Davies (1992a). On further analysis, however, these simple categories were found to have considerable depth of meaning for respondents. Knowledge, skills and personal characteristics were seen as being intimately related to each other and also as being inter-dependent in the development of competence. Most of the definitions of competence suggested by respondents were heavily qualified to contextualise meaning. In particular, concepts of relevance, appropriateness and flexibility in the practice of therapy were flagged by all respondents. Competent clinical practice was seen as being complex and determined by context. It was the result of an interaction between discipline and process knowledge, practical and technical skills and a personal stance which valued clients and valued professional learning. It depended upon the situation, the

individuals present and the degree of confidence felt by the various participants in the clinical situation.

Finally, respondents were clear that competence in SLT is an holistic concept. It includes a defined, but rapidly changing knowledge base; a more broadly defined and rapidly changing skill base; an attitudes and values base which is apparently shared, but not explicit and possibly predisposing innate personal attributes. Despite the difficulties in defining the exact nature of competence, it was agreed that it was possible to learn. Learning to become competent involves university-based and clinic-based learning in order to acquire and integrate the knowledge, skills and personal characteristics into recognisable competent clinical practice.

Chapter 9: Reporting the views of SLTs II: competence and the role of placement

9.1 Introduction

Throughout the interviews with respondents there emerged a consensus that students could learn to become competent clinicians, given a basic level of motivation both towards the nature of working with clients and towards learning. Respondents, in common with several previous authors' findings (e.g. Stengelhofen, 1993; McAllister, 2000) considered practical clinical placements to be essential to allow this learning to take place. The role of practical placements in developing competence was the second major focus of the semi-structured interviews. Respondents were asked directly what they considered to be the purpose of work-based placements, in addition, they were asked what they considered to be important in the future development of clinical education for SLT students.

This chapter explores the themes which emerged from the interviews in the context of developing clinical competence. All three respondent groups agreed that placements were a rich source of opportunity, offering access to a wide range of experience. Opportunity to work with different client groups, see different styles and different clinical environments were all outlined by respondents as being important in developing competence. 'Placements offer a rich learning environment which is people based' (AP3). Specifically, opportunities for work experience and personal and professional development were identified by respondents. Placements were seen as giving students the opportunity to learn how to 'do therapy' and learn about professional life, integrating knowledge, skills and personal characteristics identified in chapter 8, and the opportunity to develop confidence as they moved from directed to independent competent practice. A list of opportunities available or placements was produced by respondents as shown in Table 9.1.

Table 9.1: Placement opportunities

Work Experience	Comparison of real with 'ideal'. Learning how to be a worker. Personal management at work. Professional behaviour (time keeping, appearance, confidentiality etc.).
Personal and Professional Development	Integrate university and clinical learning. Develop clinical interpersonal communication. Develop confidence. Work with wide range of clients. Work with specialists working with unusual client groups. Observe and work with a wide range of clinicians (role models). Identify personal strengths and weaknesses. Practical problem-solving. Practice specific tasks and techniques.

Many of the responses here related directly to the discussions on competence reported in the previous chapter and there is therefore some overlap between the two chapters.

9.2 Competence and work experience

9.2.1 Learning at work

The first over-riding theme when discussing the purpose of placements was of placement providing the opportunity to learn about the world of work. This is a major issue in the literature on Higher Education in general (e.g. Barnett, 1994; Brennan and Little, 1996; NCIHE, 1997;) and vocational education in particular (Bines, 1992; RCSLT, 2000).

AC7 gave a strong statement of this theme:

> We can teach focused learning in groups and on site, rather than a conventional clinical placement. The placement therefore is to learn about the WORK experience, not the practice of clinical speech and language therapy skills. (AC7)

A large number of other respondents also began by indicating that there was an obvious role for placements to give students 'real life' experience. This included 'doing it for real' (AC6); 'it is important to see real-life rather than idealised

client groups (CL26). Students' statements, while not explicitly job-related, indicated the belief that placements were about work experience, and in particular moving from the idealised theoretical model and frameworks presented in University to see real cases and real ways of working.

> You need to train to do the job apart from doing the theory you need to put it into practice and get experience. It's terrifying at first. (ST91)

> It seems very obvious that you should have clinical experience before you are qualified. It would be really difficult if you qualified without ever being in a clinical situation, then suddenly be expected to run a clinic. (ST96)

While anxious or 'terrified', students nevertheless saw the placement experience as giving a realistic view of what work in their chosen profession would be like.

> I had a really good therapist like that. We saw 10 kids a day ..... She had me doing something with every child. It was great. She gave me an excellent framework to notice things and I could add things on top, then I got really good feedback. You need this. You can't just fall into a clinic and expect to just be able to do it. (ST17)

Clinicians, similarly, gave examples of opportunities to experience all aspects of clinical work on placement, comparing these with the theoretical models or ideals presented at University.

> The opportunity to see examples of what they are learning about in University and to relate the theory to the real life situation. Also to realise that what they learn in theory is not exactly what goes on in practice. It's not an ideal world and there are so many other pressures on working therapists that you need to be able to compromise. (CL43)

> As an example, we have a clutterer[1] in clinic at present. The students said they had just been learning about it and seeing the case made much more sense of the lectures – it was illuminating to realise that the theory related to a client. It's important to see real life rather than idealised client groups. (CL26)

[1] Cluttering is an unusual, complex, developmental communication disorder characterised by dysfluency, excessive rate of speech, articulation and language disturbances.

> It is very important that they learn what a clinic is like and the experience of meeting other professionals as well as clients and carers, so they can learn how they fit into the multi-disciplinary team. Background things like booking an ambulance, and other practical administration are also part of being a speech and language therapist. (CL28)

9.2.2. Learning through work

Courses offer blocks of time on placement which, in theory, offer the opportunity for intensive work experience, while half- and full-day once-weekly placements offer the opportunity to observe how clients change over time. *Placements are* at a premium and respondents recognised that it was unlikely that any student would be able to see all aspects of the range of SLT work in terms of client groups, working environment and practices, in the period of their studies. As a result, placement can only offer a partial view of working life. Some respondents from each group suggested that increased amount of time on placement would be beneficial: 'I enjoyed block placements and would like to have more blocks' (ST14); 'Ideally there would be more [placements] but there isn't enough time' (ST49), and several clinicians believed that their personal experience in University had given them a better work-based grounding than the students they now supervised:

> [I] had long block placements right from the start of the course. You felt like a therapist. You were part of a team in a department. You were sending out appointments, doing stats, answering the phone. All the things that most students don't get the chance to do with day release placements. (CL96)

> When I qualified I didn't start feeling I was walking into a job I couldn't do. I felt perfectly capable to go into a clinic and do it. My final placement was three days weekly, really 'being' a therapist, which probably helped. (CL26)

In general, however, there was agreement that students could usually achieve competence with the amount of placement available, although they rarely experienced much more than the minimum necessary.

The nature of work experience is partial, however, not only because of constraints of time on placement but also ways in which this time is managed. Clinicians reported doing their best to adapt what students see and do to their existing level of knowledge and experience, for example:

> Adult stammerers are difficult to use as clients for students. I ask them how they feel about a student sitting in on a session. It's easier to involve them in group work, where the clients can say as much as they wish and feel comfortable doing. That's the way forward for teaching students about stammering. (CL96)

> This is a diagnostic clinic, parents are at quite a raw stage because their children are just being diagnosed – that is hard for students to take on. It is difficult to let a student do the whole session whereas in year 2 the observation role is fine. At present I find I am looking for 'easy' cases for the students in 3rd year and that is not how it should be. (CL43)

But experience is constrained and students are not, as a rule, seeing working life in its entirety. It gradually became clear, therefore, that no respondent believed that placement could exactly replicate real working experience, rather, that placements provided a series of snapshots of aspects of SLT working life.

9.2.3 Priorities on placement

9.2.3.1 Students' priorities. Students have different demands upon them and different priorities from clinicians. Students saw placement as valuable in giving experience of the working environment but were acutely aware of the need to balance the placement aspect of their degree course with University based learning.

> I would like more practical experience but it is not realistic with the current course. (ST47)

> [There are enough placements] within the confines of the course length, with the timetable and lecture time. (ST48)

Placement is a part, not the whole of their working experience, and as a result they could not have the same approach to clinical work as the qualified

clinicians. In addition, it was sometimes difficult for students to treat placement as work experience because 'the pressure of clinic is that you get marked' (ST11). Most clinical placements are assessed, counting a significant proportion of marks to the final degree. Students are therefore working not only for their clients, but for themselves and this can reduce their ability to use placement as work experience.

> I get very stressed because I feel I have to prove myself. Except when things are going well. I put a lot of pressure on myself. (ST45)

Students were also aware that some clinicians viewed placements as an opportunity to assess the students' suitability for work in their own department. This went beyond the broad necessity to enable a student to achieve the required competence standards, to considering students as prospective employees and involved a more intangible concept of 'fitting in' (CL98; CL92). This capacity was, as stated by CL35 'easy to recognise but difficult to quantify'. Students therefore, were not only attempting to achieve the level of competence identified in their course documentation, but also negotiate their way through many unwritten, but nevertheless important rules of work-based behaviour.

9.2.3.2 Clinicians' priorities. Clinicians' main responsibilities are towards their clients and employers.

> Currently clinicians are not paid extra to take students therefore we rely on goodwill. They accept students in addition to existing workload which is not reduced to accommodate students. (AC4).

Clinicians themselves, while identifying only rare students as 'a nuisance' (CL26) and in many cases seeing the provision of placements as a duty to the profession, were aware of the pressures on their own working practice in taking a student. Clinicians were especially protective of their clients.

> Because I have responsibility for the child and the family..... I can't allow a session to be a disaster because that's not fair for the clients. (CL43)

The opportunity to work with clients was, however, recognised to be one of the major ways in which students could develop competence.

> Without placement students would be clumsy in clinic – and this clumsiness would be transferred to the profession, especially first posts when people are employed. (AP3)

9.2.4 Summary of views on placement as work experience

While placement was seen to give opportunities for work-based learning, there was consensus that it could not, in general terms, be the same as working life itself, because of the limits on clinical experience and the different priorities of students on a degree course compared with those of practising clinicians. Respondents outlined aspects of working at work, but predominantly learning through work (Brennan and Little 1996) as the role of clinical placements.

9.3 Competence, confidence and placements

9.3.1 Placements and fear

Lack of confidence, insecurity and fear were all mentioned by students as a part of their clinical experience.

> It is terrifying going out and doing it. It's worse when someone is breathing down your neck and watching everything you do. (ST91)

On the whole, fear was exemplified by descriptions of one-off events, but it was a strong theme. Conversely, every single student identified the opportunity to develop confidence in their ability as a key element of placement. Confidence itself appeared to be facilitated by well-planned placements, supportive therapists and the opportunity to practice and be allowed to make mistakes (something SLTs find difficult to accept (Morris, 2001)).

Students, clinicians and academics all agreed that one of the key purposes of placement was to allow students to put their university based learning to the test

and to develop their clinical knowledge, skills and attitudes in a 'safe' environment.

9.3.2 Confidence and structured placements

Structured learning was seen as one approach to reducing fear and increasing confidence on placement. Academic staff provided an overview of placement organisation, indicating how the placement experience was planned across SLT courses and integrated with the University-based learning, to facilitate development of confidence and competence. They spoke of:

> Video demonstrations.....master class for stuttering.....a final year integrating assignment.....designed to enable each student to see the whole syllabus as relevant and integrated into practice. (AC7)

> Client groups are not specified for placements but students have one child and one adult placement in each of years 2 and 3 and a mixed block in each year; one week in year 2 and seven weeks in year 3. (AC4)

> [the] student report form from supervising clinician is read by placement organiser to monitor for problems and [give an] overview of the year. Personal tutors then discuss reports with individual students. There are *also small group tutorials to address specific topic areas for clinical* problem solving. (AC6)

Clinicians were also keen to demonstrate how they organised placement experience for the benefit of students, for example:

> There is a 'pathway' used by all our clinicians who work with students. It involves learning contracts, information about their past experience of placements. We set up observation records, which the speech and language therapist carries out at least 3 times with each student. Students set out their learning goals with learning contracts. It's a whole pathway. (CL96)

Academics and clinicians were all aware of the fear aspect of clinic for students. 'Students perceive all new cases as a "physical jolt" but that is fear!' (AC7), but outlined placement organisation as one way of overcoming this:

> I expect them to look and observe general aspects of a client's behaviour – at first I just throw them in. That terrifies them, but they learn a lot from the situation. We then use observation schedules to direct them and cue them for specific elements to look for. (CL43)

> We look at what they have come out with and what treatment they have planned. Sometimes I let them go ahead with what they have planned even if I think it is not quite right, so that later on they will be able to identify what they might have done differently.....Once students get to know the client as a person a bit of the fear goes. (CL35)

This latter point was echoed by students. Learning to take account of clients' needs rather than their own when structuring their own sessions was identified by several as a fear-reducing measure.

> If you concentrate on the client and think about them rather than yourself (and it isn't always easy to manage) it helps a lot. (ST14)

A number of students felt that their confidence was impaired because of poor clinical organisation:

> I wasn't sure what I was expected to do. The role of the student and therapist was never made clear. I wasn't sure whether I was allowed to talk to the children or what I should do. (ST71)

Many others, on the other hand, gave examples of well-structured placements which were instrumental in developing confidence.

9.3.3 Confidence: clinician and student relationships

Supportive clinicians were the second sub-theme in confidence development on placement. All students valued support from therapists, and it was not exclusively the 'gentle' approach which was identified as being helpful.

> I like clinicians who tell the truth rather than patronising – overloading with praise for one small thing you have done right. You know there is a process of first positive, then criticism of negative points. I like to be treated not totally like a student, but as a fellow professional so you can exchange information. (ST17)

> A clinician needs to be more than nice and supportive. (ST49)

Clinicians also recognised the need for constructive criticism, although they also acknowledged the difficulties in this.

> It is easy for a student to become really hurt and devastated by something which is not really such a big issue. Things can get out of proportion. It is hard giving them structured help and not destroying them. Fostering the good side but getting a balance. It matters to me that they don't go away feeling awful, but at the same time you want them to get the most they can out of the placement. (CL35)

The relationship between student and clinician was also identified as being important in developing confidence, ST71's experience 'she made me feel uneasy when I spoke to her' (ST71) was clearly seen to undermine confidence, while ST96 described her most memorable clinician as:

> Constructive and positive even when she was suggesting how things could be done better or differently. I'd love to duplicate her so that every student could have her. I'm still buzzing about it...Even before I went it was such a challenge and so interesting....The supervisor was amazing. She did lots of example therapy. She was really helpful. She gave me every possible chance to find things out and practise therapy. (ST96)

Students conjectured about the reasons for variability in supervision, suggesting that at times it was the supervisor's own confidence in the supervising role which influenced the learning situation. One student described a situation she personally found difficult:

> One clinician treated me like the rest of the students till she realised I was older than her. It was very odd, as the roles seemed to reverse at that point. I preferred it the other way when she behaved like my supervisor. She had the knowledge and the experience, so when it all changed it threw me a bit. (ST91)

Other students, (although not relating this to their own personal development through experience) also identified experience as a factor in clinicians' confidence.

> Clinicians have varying levels of experience with students and this must have an effect. The less experience they have, the less they know what to expect at each level. (ST11)

All groups of respondents identified one element of supervisory process which created tensions: the need for clinicians to act not only as facilitators of students' learning and confidence, but also as assessors of competence. This influenced students' ability to treat placement as work experience (see above) but also impacted upon the development of confidence. Clinicians welcomed students who suggested their own ideas. 'If they want to disagree [with me] I think that is great, so long as they can justify what they say' (CL44), but students were acutely aware of this dichotomy of roles and the consequent caution needed in their willingness to accept or challenge clinicians' judgements.

> Clinicians give you marks..... It depends how you get on with your clinician.....Clinicians are given guidance on marking bands, but there is a lot of scope for variation. (ST 11)

Nevertheless, competence was seen to be facilitated by confidence, and this is developed especially when a student and clinician are able to 'get along' on a personal level. Regardless of the amount of structure in a placement, this element is perceived to be significant, to the extent of influencing credit (marks) for student performance. Academics, clinicians and students all identified inter-personal relationships as a foundation upon which other aspects of clinical learning and the development of confidence and competence could build.

9.3.4 Confidence and practice

The third strand respondents identified as helping to develop confidence was the ability to practice, make and learn from mistakes. Academics and clinicians referred to the inherent need for flexibility and the need to accept uncertainty as part of developing confidence and competence.

> She appeared to rush to a clinical decision, as a result missing the complexity of a case and being unable to accept that uncertainty is an integral part of proceeding towards a good clinical decision. (AC7)

> She was very forthright in her own opinions, very determined, very sure that she was right about everything. This was a student on her first placement so it was frustrating that she felt she was right about everything and wouldn't accept that she wouldn't know everything yet and that this was okay. (CL26)

Most students also mentioned this in some form:

> You learn both through things you do right and through your mistakes. (ST71)

> Being professional is about not necessarily having all the answers, but knowing how to go about finding out what to do. (ST49)

> It is also good to realise that clients don't always do what the clinician wants and that clinicians aren't always absolutely perfect as necessary. It helps to know its okay not to get things absolutely right all the time. (ST11)

Academic and clinician respondents saw practice as being important in developing competence and confidence. 'Students need to know how to "therap" and need to practice therapy' (AP1); 'need to see real clients to be able to "do it"' (AC4); 'the only time you get to practice that is on your placement.' (CL26). Finally, a pragmatic note on practice came from AP3

> Placements are expensive, but probably less so than if people were learning all their clinical skills once employed. (AP3)

9.3.5 Summary of views on competence, confidence and placements

Placements were seen by all respondents as potentially the place where students could develop not only competence but also confidence in their clinical ability. Structure, both of placement organisation throughout a course and within each placement and clinical session, was identified as a key to allowing confidence to develop. Beyond this, the relationship between the clinician and student, while difficult to describe, was also viewed as vital, with the potential to

increase or decrease students' confidence. Finally, the opportunity to practice clinical tasks and to reflect on how clinical sessions could be improved was seen to be a necessary part of work place learning, in order to allow confidence to develop.

9.4 The future of clinical placements

9.4.1 Improving placements

At the end of each interview respondents were asked what changes they would like to see in the clinical education of the future. A summary of responses is shown in Table 9.2. To a large extent while there was overlap, responses were bunched into the areas of more clinical practice, different and better clinical experience, and better communication.

It was clear from discussions with the respondents that many of the suggestions for more, different and better clinical experience were already in place in at least some of SLT courses. Throughout the interviews respondents had described placement provision, especially block placements; guidance to clinicians on the nature of experience, including indirect client-related work; University- as well as service-based placements; the linking activities designed to integrate the varying aspects in the students' experience; and some limited use of technology, which was identified as a very valuable tool in learning:

> Videos are useful in looking back and seeing what happened and helping students to see that too – what a parent did, what a child did and asking how it could have been handled differently. What we have got is a link to parents[2] to suggest how they may adjust what they do as they talk to their child. I think that would be really useful with students too – feeding into the students as they work. (CL43)

The calls for 'better' clinical experience demonstrated an acceptance that some of the desired improvements would be difficult to achieve. These included increasing HE funding, increasing the availability of technology, changing SLT

[2] A micophone-to-headphone link allowing the therapist to speak to parents to suggest changed ways of interacting with their child, without the child being aware of this communication.

Table 9.2: Aspirations for clinical education in the future.

More practice	More time on placement. More block placements. Expectation that students work as SLT assistants over summer vacations. More experience of all aspects of clinical work (e.g. different client groups; report writing; clinical administration).
Different clinical experience	A different balance of placements (block and weekly). Early active involvement on placement. More in-house clinical experience before go out into 'real' placements. More in-university based discussion of clinical cases. A balance of peer-placements and individual placements. Interesting case-books (i.e. unusual and complex as well as typical clients).
Better clinical experience	Better financing for HE to allow for fewer students or more staff to support students. Make responsibility for student supervision explicit in SLT employment contracts. More volunteers to take students on placement so that not all need to be used and clinicians can have a break from student supervision. Allow students to learn at own speed and take more or less placement time as required. Integrate 'academic' content and clinical experience (i.e. teach about client groups and have placements with these groups in close conjunction). Clearly structured and graded work on placement. Better equipped clinics in terms of technology (video, viewing rooms, IT etc.). Interactive systems to enable students to practice using assessments or computer guided learning before 'doing it' for real. Use of technology to analyse own practice. Regulation of placements by University (so that all parties understand the process). Formal assessment of clinicians as supervisors.
Better communication	Better bi-directional links between clinical and academic staff Joint planning of courses with clinicians and academic staff. Training for clinical supervisors. Identify clear expectations of all participants in clinic. Allow time for discussion in clinic. Procedures to deal with problem students. Increase willingness to allow poor students to fail and award excellent marks for excellent work. Raise status of clinical education.

contracts of employment to require acceptance of students and formally assessing clinicians' competence as supervisors, all of which were outside the immediate control of any of the respondents. Of those which could be controlled, academic and clinician respondents identified how they worked to facilitate clinical learning at a pace suitable for students, how they worked to

enable students to integrate academic and clinical experience and how they structured and monitored placements in order to facilitate student learning.

9.4.2 Communication

The major single theme which emerged from the final discussions in the interviews, as in the literature reviewed, was the need to establish and maintain communication links between clinical and university staff and students. These links were seen as an essential in order for university staff and students to understand the clinicians' working environment and for clinicians to know what students had covered at university and what was expected on placement. In part, communication was seen to be important to explain and to share current practice. All groups were clear that a shared understanding of the expectations and constraints or the other partners in the educational enterprise could smooth the process of enabling students to develop competence on placement.

> I'm not sure what happens in the in-house clinical education but students seem either to deny they have done something, or blank it out, or not covered things they need to. (CL26)

> Make sure everyone knows what everyone else expects out of placements. Give exact details. (ST11)

Equally, there was a strong emphasis on the need (although not always the opportunity) for basic and advanced courses for clinicians, to facilitate this shared understanding. 'The University does put on study days but they don't get very good attendance' (ST47). Joint planning of courses was identified by many academic and clinical respondents as being a key method of maintaining communication and in reaching agreement about the nature of competence in the SLT student. This, respondents believed, would enable a vision of future competence to develop. Beyond this, however, the entire transcripts of many respondents carried within them the need to enhance communication between individuals (students, clinicians and academics) and organisations, at informal and formal levels. This was seen as vital to increasing the status of clinical education and ultimately improving the clinical experience of students.

> [to] change the clinicians' opinions so that they were to accept students and see them as being as important as clients. (AC10)

When outlining how clinical education could be improved, respondents identified increased time on placement, different types of clinical experience, changes which would enhance the learning on placement and, an over-riding concept throughout all the interviews, a need to establish, maintain and enhance communication between academic, clinical and student partners in the clinical learning process.

9.5 Conclusion

The role of placement in the SLT curriculum might be expected to be obvious, and, to an extent the super-ordinate themes emerging from respondents would appear to support this assumption. Students were seen to require placement to learn about work and to apply their existing knowledge in new and different clinical environments. It rapidly became clear, however, that none of the respondents in this study expected the student to know all about work on graduation, indeed both clinicians and students noted that:

> when they are employing new speech and language therapists all they are interested in is if you have a Licence to Practise. They don't expect you to know anything [about working life], you learn on the job (ST11)

Basic competence was seen to rely, to a large extent, on confidence, which in turn was influenced by well-structured placements, good relationships with clinicians and the opportunity to work in a safe environment, practising skills and learning from mistakes.

One issue which arose, both in discussing competence in the previous chapter and in discussing placement in this chapter, was the fundamental requirement for academics, clinicians and students to communicate with each other. Communication about the nature of placement, expectations of the role it plays in developing competence and about the differing priorities and pressures for

each group of respondents was seen as the best way in which placements could be improved in the future.

There was a consensus that placements were not only essential, but, on the whole, an enjoyable, if scary, experience which enabled students to develop the competence for, and to learn *about the work of the profession they aspired to* enter:

> I hope by graduation to be able to diagnose, be confident the diagnosis is correct, be able to decide what to do and implement that programme of therapy. To change it if necessary. Competence is being able to satisfy the client's needs and get them to a stage which is the best they can be. (ST11)

Thus, on graduation the student may not know all about work, but should be competent and ready for work.

Chapter 10: Towards shared understandings

10.1 Overview of the findings and issues

The identification of competence in speech and language therapy is a complex process, made more complex by the fact that any discussion of competence is in danger of using a single vocabulary which means substantially different things to different people. Jessup's (1991) 'competencies' comprise only individual elements of skill; Gonczi, Hager and Oliver's competencies are 'knowledge, ability, skills and attitudes' (1990: 4) while for Spencer and Spencer (1993) a competency is a personal characteristic, which can predict job performance. Some authors see competence as deep-seated tacit knowledge (e.g. Chomsky, 1957; Polanyi, 1958) and this concept has been adopted and adapted to explore tacit knowledge and reflection in developing professional competence (e.g. Schon 1991). Authors in the field of artificial intelligence (e.g. Dreyfus and Dreyfus, 1986; Glaser and Chi, 1988) consider competence as a stage in professional development which ranges from novice performance through, potentially, to expert performance, and which is explicitly related to the context in which an individual works.

Each of these authors speaks of competence in terms of their own conceptual framework. Several use the words competency, competencies and competences but while most define their own use of words, few acknowledge the many differing definitions of these same words.

In considering the SLT literature on competence, and the development of competence through practical education, it did, at first, appear that there were significant disagreements over the nature of competence in SLT. This impression was strengthened in the initial reading of SLT course documentation, and respondents' transcripts from the empirical study. Gradually, however, it became clear that, while disagreement and differences of emphasis and priority exist in the various outlines of competence, there are, in fact, far more points of agreement than disagreement between SLTs. All SLT authors describing competence, attempted to identify what are its component

parts and how these might be measured, either individually (e.g. Davies and van der Gaag, 1992a; Williamson, 2001) or in combination (e.g. Stengelhofen, 1984; Roulstone, 2001). All reflected aspects of the broader 'competence' literature, and each in turn acknowledged that defining competence in SLT practice required attention to be paid not only to the individual's knowledge, professional and technical skills and attitudes, but the contexts in which these were to be utilised.

The SLT curriculum exists in an environment which demands increasing explicitness of detail in the aspects of competence required in an SLT graduate (RCSLT, 2000; QAA, 2001). SLT curricula appear to have moved away from a largely technocratic model (Stengelhofen, 1984). Current course documents now seem to fit Bines' post-technocratic model, and refer explicitly to competence as a super-ordinate concept. They describe competence in terms of academic and practical knowledge, academic and practical skills, and in places draw attention to attitudes towards academic and practical aspects of study and personal development as being component elements of competence.

The literature on developing professional and clinical competence on placement identifies a dichotomy between the need to identify aspects of competence at particular points in a student's (and qualified SLT's) career, most notably on graduation, and a broader, more inclusive approach to competence, which involves continuing professional development. However competence is not seen by any authors in the SLT field as being either an all-or-nothing concept at any given point, or as being two-dimensional.

The interviews with SLT respondents for this study further highlighted the difficulties inherent in describing competence. This appeared, in part, to be because of the different priorities of the three groups of respondents, and also because the vocabulary of competence and competencies was frequently used, but rarely defined. Throughout the interviews, competence was described by all the respondents as an holistic concept although the overall idea of a competent SLT graduate was recognised by many of the respondents as being difficult to specify in detail.

> It is fairly intangible what makes a student a first class Honours, but good students you feel you could work with as a colleague. (AC10)

> I tend to go by gut instinct, it's whether I feel easy watching a session. (CL26)

Eventually, however, respondents were able to discuss the nature of competence with increasing clarity. Competence was seen to require the knowledge and skill bases identified across the SLT literature and summarised by RCSLT (2000), but beyond these, in order to be considered competent, graduates were expected to use their knowledge and skills in a manner appropriate to the context in which they found themselves. Personal characteristics were considered by all respondents to be a key element of competence. It does appear that some intrinsic attributes are advantageous. The cognitive capacity to acquire the knowledge base required, and being what was loosely described as a 'people person' with an interest in other people, appear to facilitate the development of competence, but other personal characteristics, notably enthusiasm and motivation for the work, openness to new ideas, flexibility and empathy could compensate for lack of ability in other areas, especially if, as suggested by AP3, students were to be given the opportunity to learn at their own pace.

There was agreement that placement was a major learning opportunity. The purpose of placement is seen by all authors as enabling the development of clinical competence, but the varying priorities of academics, clinicians and students (e.g. McGovern and Davidson, 1982; CNAA, 1991; CSLT, 1994; Parker, 1998; Morris, 2001) have resulted in publications with very different emphases. Philosophical points are frequently drowned out by the practical issues of finding placements, meeting demands for explicit standard outcomes and attempting to agree the nature of these outcomes. All respondents identified opportunities to learn about the working environment, to develop confidence in professional activity and to practice skills, techniques and to apply knowledge in a variety of different settings, with different clients, clinicians, other professionals and other people associated with clients. Apparently simple

changes which could improve placements were identified as access to more technology (especially video and IT), more hands-on practical opportunities and more clinicians who had more interest and time for student supervision. Confidence and competence were seen as being inter-twined and all respondents focussed on confidence-building as being a crucial aspect of clinical placement.

10.2 Competence and competencies

Measuring competence is an important aspect of SLT education especially in view of the continuing demands for explicit detail noted above. In educating SLT students, threshold standards for degrees, have been produced by QAA (2001) and professional competencies are being developed by RCSLT (Williamson, 2001). Adopting the language of competencies may be of value for a variety of purposes, so long as a number of caveats are in place. As noted by Barnett (1994) and others, the purpose of education, even vocational education, goes beyond academic and operational competence, so some areas of intellectual development should also be considered to be outside the 'competence' umbrella. Additionally, in defining competencies themselves, there needs to be agreement on the content of these competencies, agreement on the level of detail and agreement on the criteria used in measuring the achievement of these competencies. As seen in the review of the literature and the interview responses, this is not a straightforward matter. Assuming that it can be achieved, however, elements of competence may be called 'competencies' as a shorthand term, although this author remains uncomfortable with the competency terminology. Identifying competencies can mean that achievement may be measured with some confidence: that the criteria are understood by each participant in the process and especially that students can see what they are expected to achieve. A competency approach may help in structuring student learning so that there is an incremental increase in demand as students progress through their course. It can also be used to satisfy outside auditors of fitness for purpose of a course of study being undertaken by students.

Judging from the literature, practical knowledge and skills are easiest to define. These may be classified in terms of technical competencies; flexibility competencies (involving a measurement of the knowledge of what to do and how to vary behaviour according to context and the behaviour of other individuals within that context); and competencies in the ability to develop models or theories of practice. Academic learning might be identified in terms of competencies of knowledge of facts, integration, synthesis, and critique of the discipline fields within SLT, and aspects of the use of theory in practical settings. Even some values and attitudes, for example showing 'positive regard' or 'empathy' might be measured in terms of competencies. Behavioural outcomes are needed for each competency, however, whether it is the ability to remember a fact, or the ability to demonstrate empathy (although the fact that someone acts in a particular way to pass a competency does not mean that they believe in what they are doing, they may simply be acting a part).

It is also argued that any competencies approach, can only be partial. The aspects of competence which are most valued by SLTs do not lend themselves to such an elemental approach. Elements of behaviour can be identified, but a person's overall stance is less identifiable in behavioural terms, while still being highly influential. Many aspects of competence (for example being easy to talk to) are easier to recognise than to measure. Enthusiasm and motivation develop alongside academic and practical knowledge and are reinforced by the level of confidence in this knowledge. These attitudes are also variable, according to whether the student has confidence in her own abilities, the relationship with the clinician and whether she enjoys working with a particular client group, or in a particular clinical setting. As an example, a student may be highly motivated in work with autistic clients, but be afraid of adults who stutter. Equally, student confidence can be increased or decreased through subtle inter-personal interactions between student, client and/ or clinician. These can give rise to emotional reactions which are often difficult for students to recognise in, or admit to themselves, still less to others (clinicians or tutors). In addition, it is the rare individual who is unfailingly enthusiastic, motivated and confident. Arguably, those who are may be demonstrating a lack of perception of situations at least some of the time.

There does, therefore, appear to be more than one level of competence. Some aspects can be identified in measurable elements, which might be termed competencies. Others, which are much deeper, result from and contribute to these measurable elements, but are themselves much less tangible aspects of competence. It can be these intangible aspects which influence judgements on the overall nature of competence, even if all individual measurable elements (competencies) appear to be present. The challenge for SLTs is to be as explicit as possible and maintain a commitment to identifying elements of competence, while acknowledging that there are less tangible, but nevertheless important and influential underlying aspects of competence which are evidenced in a student's enthusiasm, motivation and confidence, but grounded in personal approaches to, and emotional reactions to, SLT.

10.3 Competence, clinical placement and communication

Speech and language therapists are specialists in working with people who have communication disorders. It appears, however, that so far as competence is concerned, a case can be made for substantially increasing communication between SLTs themselves. Clinical placement is where the language of competence and competency becomes most difficult to translate, both in the SLT literature and in responses in the empirical study. Practical and philosophical issues are frequently tangled together. Because there are so many dimensions to competence in SLT, and because it exists not in isolation, but in context of the profession's continually changing working environment there can be no static identification of what competence is. Consequently, if students are to be educated successfully for practice, the various groups involved in that education need to communicate with each other on a regular and frequent basis, in order to explore each others' ideas, to reach shared understandings and revisit older notions about the nature and development of competence. Technology has a role to play in communication. Video and computer links are increasingly used within clinical work, but SLT is predominantly an inter-personal profession and face-to-face communication is

still the most common medium of choice for communication with clients and between students, clinicians and academics.

Increased communication would have a number of benefits. Firstly, it would allow each group to explore, and increase their understanding of, each others' priorities, the reasons for these priorities and the impact they have on SLTs' perceptions of competence. Secondly it would allow a sharing of views on the nature of SLT competence itself and facilitate consensus on how this can be identified and how measured (in terms of competencies, if these are agreed). Thirdly it would allow SLTs to explore and share their knowledge about the influences on the nature and development of competence. Fourthly, as a result of these enhanced understandings, it would allow for decisions to be made on how best to facilitate the development of competence on placement. Flexibility, enthusiasm, motivation and confidence were identified by respondents as key aspects of competence in SLT work, but without context these qualities are meaningless. Shared communication between SLTs can provide that professional context. It can help to identify the ways in which students can use their knowledge, skill and personal characteristics across a wide range of professional situations, increasing their ability to work professionally as a result.

In order to improve student education for practice in the future, there needs to be agreement on what basic SLT competence is. This, to a large extent, appears to be present across the literature surveyed and between the respondents interviewed for this thesis, although the actual level at which competence is considered to be present is disputed in the fine detail. There also needs to be an agreement on the ways in which competence can be facilitated and developed on clinical placement. The knowledge base will change, new approaches to therapy will require new skills and techniques and the changing working environment may well demand changing personal characteristics in the SLT profession. Understandings will therefore also change, and consequently the need for communication between academics, clinicians, students and others involved in clinical work is one which must be ongoing, regular and frequent. The expectations of each of the three groups need to be discussed, and keep on being discussed, in order to build shared

understandings of the nature of competence in SLT, especially in the new graduate, and the ways in which this can be developed and measured throughout the course, especially in the practical elements of the course.

Table 10.1 Levels of communication on SLT student competence

Level	Who involved	Topics	Communicated how
Macro	Regulatory bodies (RCSLT; CPSM/CHP; QAA). SLT academics and managers as part of these bodies. Researchers.	Identification of professional competence within the regulatory structures. Course content; fitness for purpose (academic and professional) of courses. Good practice guidelines. Recruitment and retention within the profession. Direction and development of the profession.	Formal meetings; working groups. Web-based and written publications: lists of registrants; professional guidelines; degree benchmarks; books; research papers; conference presentations; magazine articles.
Meso	SLT course teams, local SLT services (managers and clinicians) and students.	Negotiated agreement on the identification and component elements of competence (competencies) in the pre-qualifying student. Identification of the development of student competence during the course of their studies. Course aims; course development and delivery. Negotiated agreement on availability, nature and purpose of placements. Negotiated agreement on structure of placements. Priorities of each group and how these impact upon the others.	Formal meetings; working groups; study days; special interest groups; workshops; conferences; video-conferences; web-based discussion groups; e-mail; small group discussion; informal conversation. Written course documents; placement guidelines; assessment protocols.
Micro	Individual SLTs providing placements, individual students and academic tutors.	Clear outlines of the elements of practical development (competencies) expected during the current placement. Open discussion of concerns, fears and aspirations of each partner in the current placement. Open discussion of the priorities of each individual and how these impact upon the others.	Pre-placement workshops and guidelines; individual discussion at the start of placement; observation opportunities and session-by session support and guidance with feedback on therapy sessions; e-mail and telephone contacts. Video feedback to allow self-critique. Assessment grades.

As shown in Table 10.1, communication must be at all levels. It should be multi-directional, rather than involving simply one group or individual telling another what they consider to be needed. Communication should not be either

simply formal training or a one-off event and there needs to be continuity and re-initiation of communication on a regular and frequent basis if student learning is to receive priority.

10.4 Conclusion

This thesis addresses competence in pre-qualifying SLT education. SLTs need to be rounded human beings. Their education must allow them to develop their own critical faculties, applying knowledge, skills, their personal characteristics, personal experience and understanding to the field of SLT. As students they will develop the intellectual capacity to engage with new ideas in a field where there are no easy or straightforward answers. SLTs must take into account linguistic, psychological, social and medical aspects of communication disability, at the same time as acting to reduce the impact of that disability for the individuals concerned. SLT students learn individually defined skills, but these need to be incorporated rapidly into a broader competence base, raising difficulties for those who wish to quantify every aspect of a student's clinical learning and behaviour. This thesis argues, however, that such an approach to measuring skills is not only unnecessary but undesirable. Measurement of observable skills alone runs the risk of only measuring what can be easily quantified and disregarding the deeper cognitive structures involved in competent clinical performance. By the time an SLT student graduates, many of the sub-structures of problem solving activity have been buried deep in the subconscious. They are no longer at the forefront of cognition and are not stored linguistically, but are embedded in the individual's tacit knowledge base. Practical work which appears to rely exclusively on intuition is, it is argued, the result of deep-seated learning which involves technical expertise, hypothesis formation, a professional value base, and an enhanced capacity for inter-personal communication.

Several authors (e.g. Pletts, 1981; Roulstone, 2001) and respondents (e.g. CL29) use mapping metaphors in their descriptions of developing competence and these are useful in conceptualising the progression towards competent clinical practice. Students start their journeys at different points. Some are

further along the road then others when they commence their degree, and all may find diversions and alternative routes towards the destination of competence. Some of these routes may lead to dead-ends, some take a scenic tour while others are relatively direct, requiring only minor re-adjustments along the way. Taking a geographical metaphor further, the development of competence may be seen as a mountain-climbing exercise. The goal of competence can be seen in the distance, but the route is a succession of ascents, detours and occasional descents across a mountain range, with progress being guided and checked at various points to ensure the student is on track to reach the destination. Some students may give up the attempt to travel, or choose an alternative destination, some take a route which is less challenging, which takes more time, while others climb the steepest track in order to reach the summit early. Convergence upon competence as a destination is, however, still only a point on the route. Beyond it graduates may travel further into the mountains, exploring the broader plains of proficiency, or climbing to higher peaks of expertise in specialist areas.

The mark of the competent SLT graduate is the ability to use their capabilities in a wide range of contexts while responding to novel situations involving communication disability. SLT education aims to enable the development of a graduate who has achieved basic competence, but who also has the tools to continue to learn and change practice throughout their professional life.

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Appendices

Appendix 1: SLT course content guidelines

Appendix 1.1: International Association of Logopaedics and Phoniatrics guidelines for course content

Language sciences
Linguistics (phonology, syntax, semantics, lexicons, discourse, pragmatics) Language acquisition Socio-linguistics Polylingualism Phonetics Acoustics Audiology (relevant to linguistic sciences) Production and classification of speech sounds Practical data collection, transcription and measurement.
Behavioural sciences
Cognitive psychology Social psychology Developmental psychology (across the age-span) Psycholinguistics Neuropsychology Education/pedagogy Studies of personality and individual differences Practical work to include research methodology and the application of quantitaive statistical analyses
Bio-medical sciences
Biological bases of language and speech (including neuro-anatomy and physiology) Clinical medical sciences as applied in neurology, otorhinolaryngology, paediatrics, geriatric medicine, psychiatry, audiology, ortho-dontics and cranio-facial anomalies and their repair, and of deglutition Practical work to include observation of cases
Logopaedics (speech pathology and therapy)
Study of: Varieties of abnormal communication, characteristics and possible causal factors Theories of the assisted establishment/ recovery of language function Culturally and linguistically appropriate methods and resources for assessment Culturally and linguistically appropriate methods and resources for intervention Methods of evaluating the effectiveness of intervention Consequences of communication disorders for the families and social contacts of the individuals and methods of counselling Social and organisational contexts in which SLTs work, work of allied professions, legal and ethical issues, use of resources and professional responsibility Practical work to include either directly or through video-taped demonstration of cases with communication disorders in at least some of these areas.

Appendix 1.2: Clinical experience: Minimum clinical sessions required by RCSLT

Required clinic based experience: 100 sessions (300 hours) minimum	
To include communication disability resulting from: autism, bilingualism, cerebro-vascular accident (stroke), degenative neurological disorders, developmental delay, developmental speech and language impairments in adults, disorders of fluency, dysphagia (swallowing difficulties), head injury,	hearing impairment, infection, learning disability, mental illness, multiple handicap, neuro-surgery, physical disability, structural abnormality, voice disorders.
Allowable non-clinic based experience: 50 sessions (150 hours) approximately	
Sessions	**May include:**
Related experience; visits to/ placements in:-	Nurseries, playgroups, schools, residences for the elderly, ATCs, hospitals, support groups, other professionals.
Focussed clinical teaching:	Discussion of videos of clients and students, master classes, simulations and role play, case presentations, tutorial discussions, clinical seminars, interview workshops, guided practice with clinical resources, videoed discussions.
Student directed learning:	Interactive videos, work-books, client/ case studies, student directed seminars, peer tutoring, video/ audio analysis.

Appendix 2: Three examples of SLT course aims

Course 1 (3 year undergraduate Honours degree)

The course aims:

1. To enable students to develop as independent learners.
2. To enable students to acquire the relevant knowledge skills and professional competence. required to practice as speech and language therapists.
3. To prepare students for employment in a variety of settings.
4. To enable students to develop an evaluative approach to their own professional practice.
5. To provide opportunities for students to develop confidence in interpersonal skills.
6. To enable students to develop a framework of knowledge and skills for ongoing professional development.
7. To assist students to develop the ability to analyse and synthesise knowledge from a range of academic disciplines.
8. To encourage students to take an holistic approach to their work with clients with communication difficulty.

Course 16 (4 year undergraduate Honours degree)

The course aims to produce graduates who:

1. Are able and motivated to think systematically and creatively about the nature of communication difficulties and the intervention of the speech and language therapist.
2. Have adequate knowledge of theoretical disciplines which underpin different aspects of speech and language therapy.
3. Have adequate knowledge of research on the nature of communication disabilities and approaches to intervention.
4. Draw on their knowledge appropriately in their clinical practice.
5. Have adequate personal and social skills to work with people who have communication difficulties, their carers and other professionals.
6. Have adequate knowledge of the health and education settings in which speech and language therapy takes place.
7. Have organisational skills.
8. Have a grasp of research questions and methods adequate to participate in collaborative research or embank on their own research in the field of SLT.

Course 18 (2 year Masters degree)

Aims of the programme are:

1. To provide a University education which will develop clinical facilities in the students and equip them with ability to make judgements on the basis of scientific analysis.
2. To cultivate in the students an awareness of the complexities of approaches used in its study.
3. To stimulate the student's curiosity and excitement in the study of disorders of communication and the variety of approaches used in its study.
4. To provide a vocational education leading to a qualification in speech and language therapy, producing therapists who:
   a) Have a basic competence in recognising and analysing communication;
   b) Have baseline resources to develop further skills after completing the programme and to advance the profession through research into language disability;
   c) Are responsive to the changing needs of the provision of services in speech and language therapy;
   d) Are capable of developing new insights into communication disorders, their remediation and planning of services.

Appendix 3: Interview questions

Appendix 3.1: Sample of pilot questions

QUESTIONS/ INTERVIEW FOR SPEECH AND LANGUAGE THERAPY EDUCATORS

A. Practical issues

1. How are student placements organised on your course [why are they done in this particular way?]

   Number of placements
   Types of placements
   Demands of placements

2. How easy is it to find placements? What strategies do you use?

3. Do you give clinicians any guidelines for placements? If so what and how?

4. What other links do you have with employers?

   Local individuals
   Institutional level (managers)
   NHS/ other at policy level

   Do these influence your demands for clinical placement activities? CPSM – views on potential changes following joining of this organisation?

5. Do you have an on-site/ in-house clinic? If so, how does it work?

6. Do your speech and language therapy qualified staff have clinical duties? If so, what sort?

   Regular clinic:
   - Weekly
   - Block
   - Other

   Irregular:
   - Consultancy
   - Second opinions
   - Legal expert witness

   Private practice

   Clinic visits

   Clinic assessments

   Appraisal of placement providers

   Courses for placement providers

   Other?

B. Issues in clinical learning

1. What is the purpose of clinical placements?

2. How do you define clinical competence?

3. Describe the characteristics of the most memorable student you have ever supervised (good or bad).

4. How do you encourage students to relate theory to practice?

5. How do you encourage students to use their practical experience to develop professional competence?

6. How do you make decisions during a therapy session? Can this form of decision-making be taught?

7. Do you think students require:

   More education
   Less education
   Different education

   More training
   Less training
   Different training

8. To what extent does a speech and language therapy degree have professional validity?

9. To what extent does a speech and language therapy degree have academic validity?

Appendix 3.2: Semi-structured interview. Academics

INTERVIEW WITH SPEECH AND LANGUAGE THERAPY ACADEMICS

Respondent .....
Date.....

Questions	Prompts
How do you encourage students to relate theory to practice?	Definition of theory
What is the purpose of clinical placements?	RCSLT requirements? Philosophical approach?
Describe the characteristics of the most memorable student you have ever supervised (good or bad)?	Is a therapist born or made? Are we in danger of only recruiting people who "fit" the stereotype? If so, how do we avoid this?
How do you define clinical competence?	NVQ approach? Novice to expert continuum? Capacity to continue to learn?
How do you encourage students to use their practical experience to develop professional competence?	
How do **you** make decisions during a therapy session?	Intuition? Technical skill? Reflective practice?
Can this form of decision-making be taught?	If so, how?
Is there a difference between education and training?	What? Do we do one or both? Should we do more of one or the other? Why?
What do you think we could do to make clinical education more effective?	Different models of practical experience... if so, what?
If you could do one thing to improve clinical education over the next 5 years, what would it be	Magic wand

Thankyou

Length of interview .....

Appendix 3.3: Semi-structured interview. Students

INTERVIEW WITH STUDENTS

Respondent/s: .....
Date.....

Question	Prompt
What is the purpose of clinical placements?	Do you enjoy them? Why?
How do you define clinical competence [as speech and language therapy students]?	
What helps you to relate theory to practice?	
Think of sessions you have carried out. How do you make decisions during a therapy session? How have you learned to do this?	Intuition? Technical skill? Reflective practice?
Describe the characteristics of your most memorable clinical supervisor (good or bad).	
Is there a difference between education and training?	What? Do we do one or both? Should we do more of one or the other? Why?
What do you think we could do to make clinical education more effective	Fewer hours but better controlled...if so how? More in-house? Different models of practical experience... if so, what? Utilise more technology... if so how and where?
If you could do one thing to improve clinical education for students on your course what would it be	Magic wand

Thankyou

Length of interview .....

Appendix 3.4: Semi-structured interview. Clinicians

INTERVIEW WITH SPEECH AND LANGUAGE THERAPY CLINICIANS

Respondent/s: .....
Date: .....

Question	Prompts
How long have you been involved in clinical placements	
What is the purpose of clinical placements?	Practical reasons? Philosophical approach? RCSLT requirements?
How do you encourage students to relate theory to practice?	Definition of theory
Describe the characteristics of the most memorable student you have ever supervised (good or bad)?	Is a therapist born or made? Are we in danger of only recruiting people who "fit" the stereotype? If so, how do we avoid this?
How do you define clinical competence?	NVQ approach? Novice to expert continuum? Capacity to continue to learn? Who are we trying to please?
How do you encourage students to use their practical experience to develop professional competence?	
How do **you** make decisions during a therapy session?	Intuition? Experience? Technical skill? Reflective practice?
Can this form of decision-making be taught?	If so, how?
What do you think we could do to make clinical education more effective	Is there a difference between education and training? What? Do we do one or both? Should we do more of one or the other? Why? Fewer hours but better controlled...if so how? More in-house? Different models of practical experience... if so, what? Utilise more technology... if so how and where?
If you could do one thing to improve clinical education over the next 5 years, what would it be	Magic wand

Thankyou

Length of interview .....

Appendix 4: Recruitment correspondence.

Appendix 4.1: Letter and enclosures to academics and clinicians.

Headed paper

date

Dear Colleague

EdD research: education for practice in speech and language therapy

I am currently undertaking the thesis stage of an EdD, based at Durham University. As part of the research I am carrying out semi-structured interviews with speech and language therapists involved in placements. I would be most grateful if you would be prepared to spare around 1½ hours to be interviewed.

I attach the recruitment details and question areas. If you are interested, please would you return the reply slip indicating good times and dates. I can travel to your base most Thursdays or Fridays from mid June and I am available at any time between 9 am and 9pm

Many thanks.

Yours sincerely

JOIS STANSFIELD MSc DipCST RegMRCSLT
Senior Lecturer

(Direct Dial: 0131-317-3683)
(e-mail: j.stansfield@sls.qmced.ac.uk)

REPLY SHEET

EdD research: education for practice in speech and language therapy

I am willing to be interviewed for this research project.

Name:_____ Address: _____

_____

Phone:_____ _____

_____

Suitable times and dates would be:.....

Semi-structured interview procedure (each group separate from the others)

1. Clinicians

Criteria - supervising speech and language therapy students on placement

1-2 clinicians

not qualified from QMUC recently

Process - individual or group interview - face to face
- audiotaped

1½ hours approximately
question areas pre-notified
transcripts returned to respondents for correction/comment
written consent form sent with the transcript

2. Students

Criteria - final year/s
1-3 students
not QMUC students

Process - individual or group interview - face to face
- audiotaped

1½ hours approximately
question areas pre-notified
transcripts returned to respondents for correction/comment
written consent form sent with the transcript

3. Speech and language therapy lecturers

Criteria - one per institution
involved in clinical education of speech and language therapy students
not QMUC staff

Process - individual interview - face to face
- audiotaped

1½ hours approximately
question areas pre-notified
transcripts returned to respondents for correction/comment
written consent form sent with the transcript

Confidentiality

All material will be secured in a locked filing cabinet.

All transcription will be undertaken by the researcher, or by a research assistant to whom respondents are unknown.

All views will be anonymised for the EdD report and any subsequent publications.

All raw data will be destroyed no later than 5 years after the completion of the EdD report.

Questions: speech and language therapy educators

How do you encourage students to relate theory to practice?
What is the purpose of clinical placements?
Describe the characteristics of the most memorable student you have ever supervised (good or bad)?
How do you define clinical competence?
How do you encourage students to use their practical experience to develop professional competence?
How do you make decisions during a therapy session?
Can this form of decision-making be taught?
Is there a difference between education and training?
What do you think we could do to make clinical education more effective?
If you could do one thing to improve clinical education over the next 5 years, what would it be?

Questions: SLT clinicians

What is the purpose of clinical placements?
How do you encourage students to relate theory to practice?
Describe the characteristics of the most memorable student you have ever supervised (good or bad).
How do you define clinical competence?
How do you encourage students to use their practical experience to develop professional competence?
How do you make decisions during a therapy session?
Can this form of decision-making be taught?
What do you think we could co to make clinical education more effective?
If you could do one thing to improve clinical education over the next 5 years, what would it be?

Appendix 4.2: Sample letter and enclosure to students

Headed paper

Date

Dear Students

EdD research: education for practice in speech and language therapy

I am currently undertaking the thesis stage of an EdD, based at Durham University. As part of the research I am carrying out semi-structured interviews with a range of speech and language therapy clinicians involved in student placements, students and lecturers.

I would be most grateful if you would be prepared to spare around 1½ hours to be interviewed in the afternoon of Wednesday (date) from around 2pm.. {Named lecturer} has very kindly arranged to organise a room.

I look forward to meeting you.

Yours sincerely

JOIS STANSFIELD MSc DipCST RegMRCSLT
Senior Lecturer/Course Leader

(Direct Dial: 0131-317-3683)
(e-mail: j.stansfield@sls.qmced.ac.uk)

REPLY SHEET

EdD research: education for practice in speech and language therapy

I am willing to be interviewed for this research project on the date indicated in your letter.

Name:_____ Address: _____

_____

Phone:_____ _____

_____

Semi-structured interview procedure

Students

Criteria - final year/s
1-3 students

Process - individual or group interview - face to face
- audiotaped
1½ hours approximately
question areas pre-notified
transcripts returned to respondents for correction/comment
written consent form sent with the transcript

Confidentiality

All material will be secured in a locked filing cabinet.

All transcription will be undertaken by the researcher or by a research assistant to whom respondents are unknown.

All views will be anonymised for the EdD report and any subsequent publications.

All raw data will be destroyed no later than 5 years after the completion of the EdD report.

Question areas: SLT students

What do you consider to be the purpose of clinical placements?
How do you define clinical competence?
What helps you to relate theory to practice?
Think of sessions you have carried out. How do you make decisions during a therapy session?
How have you learned to do this?
Describe the characteristics of your most memorable clinical supervisor .
Is there a difference between education and training?
What do you think we could do to make clinical education more effective?
If you could do one thing to improve clinical education for students in the future, what would it be?

Appendix 5: Number of respondents in each interview

Respondents	Number in each interview	Number of respondents	Total
Academics	1	10	**10**
Students	1	2	
	2	4	
	3	6	**12**
Clinicians	1	6	
	2	4	**10**
Total			**32**

Appendix 6: Letter and enclosure accompanying transcripts sent to respondents for approval and release.

Headed paper

Date

Dear

Interview transcript: education for practice in speech and language therapy

I am writing to thank you very much for your time in being interviewed in [month].

I have also attached a consent form and a brief outline of the project, which has received ethical approval from the School of Education, Durham University.

I would be most grateful if you could read over the transcript, making any additions or deletions you wish. Once you are happy with the content, please sign the consent form and return the transcript and consent form to me, to allow me to use the data as part of my thesis.

Many thanks once again.

Jois Stansfield MSc, Dip CST, Reg MRCSLT
Senior lecturer/Course Leader

(Direct dial: 0131 317 3683; e-mail: j.stansfield@qmced.ac.uk)

Headed paper

Permission form: EdD thesis

I have read the transcript of my interview and have corrected any areas where I believe my views to have been incorrectly interpreted.

I understand that the raw data (cassette recordings) will not be in the public domain.

I understand that the information will be anonymised and that any individual views or quotations will be identified only by a letter and number code.

With these assurances, I agree that data from this transcript may be used as a part of Jois Stansfield's EdD thesis.

Signed .....

Date .....

Appendix 7: Sample transcripts

Appendix 7.1:
Interview transcript respondent AC5

How do you encourage students to relate theory to practice?

Don't separate out clinical teaching and theoretical teaching for specific client groups, instead present theory and then interweave real clients as examples.

There is a professional studies course which looks at general issues in clinical work such as case history taking, interviewing, report writing. Students are expected to read and relate this to theory.

Clinical assessments have explicit requirement for students to use theory to justify their practice.

All placements have clinical objectives, which are not tied to client groups. In addition, students select clinical objectives for themselves (in consultation with clinician) to develop personal learning.

There are some individual tutorials and some (more) group tutorials in Years 3 and 4 where specific clinical issues are discussed.

Any further comments?

None

How do you define theory?

Research findings. Evidence based intervention. Sometimes expert opinion, if this is all that is available. What you read that backs up what you do.

Any further comments?

Explanations/ models for how/ why processes occur.

What is the purpose of clinical placements?

You can't teach students in a lecture theatre to be a good clinician. They can learn something from role play, watching videos and commenting, in-house clinics, but they need to meet and work with real clients.

What helps – seeing another clinician do something and then working with the same client. This gives the opportunity to use theory and see if it works in practice.

Modelling on behaviour of clinician, but developing own style.

Enables critical evaluation of clinician's and own work.

Need practice to embed skills "automatic". This allows more conscious energy into more difficult bits. In a new situation, may feel to go backwards as things are no longer automatic.

RCSLT clinical hours are probably sufficient although ideally could do much more. It is a balance of the availability of placements and the level of competence of the graduating student. If they have fewer placements, "you pay them when they are qualified" to develop further competence with supervision in their first year or two.

Students will never have the opportunity to work with every client group. There are "core competencies" but there are also specific client-group-specific skills which may

need to be developed post-qualifying. Students do not, therefore graduate with "across the board" skills.

Any further comments?

None

Describe the characteristics of the most memorable student you have ever supervised.

Poor student 1
Social skills difficulties – these are on the border of whether it is something which should or could be addressed with the student. Inappropriate behaviour. Too loud, informal, slightly getting it wrong. Difficult to know how to tell the student they are getting it wrong without damaging the student's morale.
Speech and language therapists are not good at addressing these issues and being critical or assertive to the individual.

Poor student 2
Failed final placement. Looked fine on paper in placements. Informally clinicians now reporting concerns which they did not express at the time. Poor interpersonal skills and poor at team work. Possibly again being given inappropriate (though well-meaning) supervision.

In general socially skilled inter-personal behaviour and ability to work in a team are central to speech and language therapy, but very difficult to judge it and deal with it when there is a problem. Personality.

Recruitment – can you spot "it" when they come in?

There is a risk in taking students who are very young and still changing, but therapists are not necessarily born but can be made. Can usually spot the very poor ones, but not necessarily. At the age when many students start university they are having to learn to cope with a lot of personal and academic change which can affect clinical work.

Some students have been taught how to behave at interview. If they have been taught that, can probably teach them other appropriate social skills for clinical purposes.

Probably less good at spotting potential in people from the wider range of social backgrounds we want to recruit, as we have less experience.

The interview process probably doesn't select efficiently the people we do want.

Any further comments?

None

How do you define clinical competence?

The ability to do all aspects of the job well, rather than individual bits "competencies". To recognise what you can't do. To manage your job.

Time management.

Expectations management (do what you are paid for).

Do the job, do it well, and do it within the hours you are paid to do it. Makes you a better therapist and a better person if have outside interests and a "life". (Need to be able to balance professional and personal lives.)

Speech and language therapists need many competencies. Lots are transferable but some are specific to particular client groups/ages, and a limited number of specific competencies can be acquired on the undergraduate course.

The end of the course in not the end of learning. Graduates will spend less time reading and more time doing. Different types of learning come in – e.g. clinical management, case-load management – increased speed of reaction. Life long learning is important.

Any further comments?

None

How do you encourage students to use their practical experience to develop professional competence?

Give written guidance on the aims of each placement. Objectives and competencies model helps students to focus on the kind of abilities they are trying to develop.

Give information on the differing models of intervention. Encourage clinicians to allow students to go beyond the ½ hour individual therapy session and see the range of the job.

Encourage students to recognise that most aspects of clinical placement can be used for learning – with guidance from clinician (lots of examples of interpersonal skills).

Give students explicit encouragement to observe at different levels (including what clinician does, parent does, etc) but not all at once.

Any further comments?

None

How do you make decisions during a therapy session?

Plan first, either in head or on paper for a focus.

Be prepared to abandon the plan if it seems appropriate (therefore applying existing background knowledge, technical skills and previous experience).

Judge whether time being taken will give sufficient return (e.g. AAC users doing TROG) or whether an alternative approach will achieve an acceptable result.

Therefore e.g. time available; decision on use of time; fast strategic thinking on-the-feet; observe effect (e.g. if child restless/bored) and adjust on "autopilot" without necessarily being consciously aware of it at the time. This frees up mind to be more flexible in difficult areas.

Use the ability to be flexible and confident.

Any further comments?

None

Can this form of decision-making be taught?

Yes. Students need to have clinical decision-making broken down so they have one element to think about at once.

This allows students to establish the basics and then concentrate on higher level skills.

Any further comments?

None

Is there a difference between education and training?

Training:
Apprenticeship to do the job as it is now.

It allows the activity to be seen at a superficial level – a "cook book" approach assuming a single answer.

Education:
Understanding the principles which allow decision-making, and being able to apply these to particular cases – i.e. chose appropriately from available techniques for assessment and intervention.

Need some training as well as education but concerned that some people would like speech and language therapists to have more training and less education.

Any further comments?

None

What do you think we could do to make clinical education more effective?

Make the responsibility for student education explicit in the clinician's employment contract. Many managers chose to ignore this responsibility, others are very good at ensuring the expectation.

There is no longer a separate payment for taking students. Perhaps there should be and the change in funding for undergraduate education may facilitate this.

There should be a recognised training for taking students (locally 4 institutions are collaborating on in-service courses) with nationally recognised qualification (RCSLT or CPSM) similar to probation officers?

Any further comments?

None

If you could do one thing to improve clinical education over the next 5 years what would it be?

Create more placements and a wider range.

Employ clinicians with a specific responsibility for taking students on placement (local region has done this but only for 2 years).

Any further comments?

None

Appendix 7.2:
Interview transcript respondent CL35

What is the purpose of clinical placements?

There is a lot of groundwork done in the theory and you have got to get the theory under your belt, or at least have a grasp on it before you can begin to benefit from a placement. The clinical placement is about doing the job, but also recognising the reality. You have the theory and an idea of how it might be applied, but the reality of being out in a working environment, with all the distractions and all the side issues, and all the things you have to do to think ahead and think around, that is what the placement is about. You are dealing with real human beings with their own lives. It is being able to think holistically, see beyond the task to recognise when you need to adapt or modify. If students just have dry theory and scenarios they can't apply it to real people – and they fail.

You've got to be able to see beyond a theoretical situation. You can see the client, analyse the communication problem and decide what they need in theory. What students have to learn is to look not just at what they are focused on, but to see outside of that and relate with professionals, peers, relatives. Those are skills they have to develop on placement. Even if they are great academically, if they sit there unable to 'read' the person in front of them, they have got big problems. It's about taking theory into the real world, in a real setting.

The quality of clinical placement is important. Quantity is less important than quality. They need continuity, quality and a breadth of placements in order to learn.

Students need placements if they are going to develop into practitioners. They are very draining, but if you want to do anything for the profession, you've got to take students and give them the time. It is an investment in the future even though it is a pain sometimes. A good student will take up time and you don't mind. If they are not committed they don't take notice, or even answer the phone. You need some initiative.

When I trained we were straight into placement – I liked this. I never felt a huge gulf between the theory and the practice. You always had somewhere you could go and practice and have a go, and talk about it with someone who really did it. It could be terrifying, but you felt as though you knew what was ahead of you.

I've had students in their final year who have never seen an adult client. They will have seen videos and peer reviews, but not worked directly with an adult. They are petrified because they don't know how to speak to another adult. They need the right kind of placement and the right kind of range.

You feel sorry for students. You want to get the best from them so you have got to be quite hard to do that. You have to push them a bit. They are frightened, it's like standing on the edge of a swimming pool – you've got to get them to try.

I try to remember what it was like to be a student. I try not to make them feel awful, but at the end of the day there is a job to be done and they must learn how to do it.

Sometimes students seem to forget why they are on placement. It is not because the tutor says they have to, its because they want a career in this profession.

Any further comments?

None

How do you encourage students to relate theory to practice?

I always try to get the student to think about the person (client). In my field (voice) you can't separate the voice from the person. I like them to do a thorough history, identify what the problem is, how it arose and what needs to be done. I encourage formal analysis to collect real hard data, using the computer as well as perceptual analysis. I expect them to look at the findings this and relate this to the theory. Once they have done that we look at what they have come out with and what treatment they have planned. Sometimes I let them go ahead with what they have planned even if I think it is not quite right, so that later on they will be able to identify what they might have done differently. This is not to let them fail, but to let them find out in their own time. They come to realise that a theoretical management plan can be highly inappropriate at times and a therapist must be able to tailor their practice to patient needs.

Sometimes you learn better by doing that. Other times if I think they will struggle with the way they have planned something, I will try to help them look at the plan systematically, talk about why they had thought of doing certain tasks and possibly redirect them so that they will be more successful.

I ask them to break things down, analyse salient points in relation to the theory, have an idea of how they might apply the ideas – actually try it in a real situation, reflect on how it went and see if they can identify how they might change things.

I like them to do as much as they can themselves because I think they feel a sense of achievement. Even if it's gone wrong, if they can say what they could have done instead, they are realising that they are starting to work things out for themselves.

A lot of students tend to knock themselves. The last 2 I have had have not been able to see anything good. Partly it is because they have not had any relevant experience. They have a huge learning curve – all the clinicians here are telling them what they need to do. It is not negative; we try to be as positive as we can, but the students end up feeling as if they know nothing. They see it as their own fault, but it is not. It's the fault of their education. The way placements are organised means that they don't know enough about what they should be doing with this client group. They then see everything as negative and often knock themselves. We have to balance that with getting them to think about what they did well, and us noting down what they did well. Its not that much different from what you do with a client – encouraging them to see the good things. It is easy for a student to become really hurt and devastated by something which is not really such a big issue. Things can get out of proportion. It is hard giving them structured help and not destroying them. Fostering the good side but getting a balance. It matters to me that they don't go away feeling awful, but at the same time you want them to get the most they can out of the placement.

Once students get to know the client as a person a lot of the fear goes.

Students coming 1 day a week over a long period gives continuity so this was good. Blocks are fine, and students need them but they also need continuity and follow-through with the clients otherwise they can get away with quite a lot. I want them to have to think and plan and structure.

Any further comments?

None

How do you define theory?

In SLT, broadly this relates to information you have been given in University and from research journals and current thinking. Factual information (supposedly factual!), ideas that other people have come to by measuring what they do, which appears to be an efficient way of achieving a goal and allows further development and modification. An

accepted set of ideas or methods relating to the most effective procedures to adopt to address a client's needs. Information relating to the type, nature and cause of difficulties

You need a baseline knowledge of broad issues which you can then develop a plan. A knowledge of disorders, treatment, how to plan, evaluate and modify

You should always be thinking yourself, to develop your own knowledge. It is much more interesting that way. You wouldn't just take a theory and apply it blindly.

Any further comments?

None

Describe the characteristics of the most memorable student you have ever supervised

A good student: interested, aware, motivated. She had good social skills. She knew when to involve herself and when not to. She could read situations effectively. She was an independent learner – went and read and told you when it was relevant, but not just to impress. Lively, lots of energy. She looked as if she wanted to do the job. Pleasant to have around, asked lots of questions but was not demanding because of the way it was done. She was good at noticing other people.

I'm not sure that some of these things can be taught. There is an issue in who is recruited to courses. I am not sure the "right" people are always selected. Attitude is so important – attitude, social skills and general manner.

As a student , everyone is aware of people in their year who are not "right" for the profession. So how did they get in? There must be a way of working it out for selection. Students need "emotional intelligence".

It is easy to recognise but difficult to quantify. The basis is being able to relate to people properly. The courses are an arts and science blend.

Is a therapist born or made?

It sounds as if I am saying born. There is a personality type which lends itself to these types of employment, but it is dangerous to say it is born and not made. It is too arrogant. There are some people it comes more naturally to than others. Some people can do things instinctively and other don't (its not negative or positive). But I don't think a therapist is born.

Are we in danger of recruiting only people who fit the stereotype of an SLT.

No. People with the qualities I mentioned can come from a wide range of backgrounds.

Any further comments?

None

How do you define clinical competence?

You have to decide who's perspective you are measuring it from. Client satisfaction – is very important. From another perspective, it may be about making sure that you are well informed about current issues. You should monitor your practice and make sure you are developing that. Reflecting, measuring from whatever perspective is most relevant. Looking at your outcomes, making sure you try to remain efficient and capable of providing the best service to clients. Performing to a minimum standard..

Taking the time to have procedures to structure what you are doing. Thinking about what goes into a particular process. For example in a laryngectomy case, if someone has a valve fitted as a secondary procedure, what should be involved in that in a normal case. A 'care pathway' so that there is a broad structure that everyone can attempt to conform to or have as a baseline. It's easier to measure that and to know how to develop on from that. It's hard to define what competent is, but having some way of structuring and measuring in a broad way it is a good start. But if this is imposed rigidly, you lose all flexibility and that is not competence.

Competence is not just ' getting someone better' or a particular number of 'face to face contacts'! It's about having an outcome which is positive and acceptable to the client. Client satisfaction is the most important. A medical model, with assessment results being measured is not our purpose. It is about quality of life – client based not disorder based. For example a client with vocal nodules – the outcome should be whether their voice meets their needs. You need to find out if the client sees something as a problem, and if then fit what they want with what is your own criteria for what it is appropriate to offer.

I used to be very disorder-based but as I have gained more experience I do use instrumental measurement and assessment, but what matters is whether the clients feels they have received a service which has improved their quality of life. In laryngectomy, quality of life has very little to do with which valve has been fitted and what size it is. It is to do with how well they can function in the real world and how much their day has to be spent thinking about their disability – things like not being able to carry shopping bags and talk at the same time.

If you ask the average person who has been through the system (which we should do) they talk about what the therapist did and how it helped.

Competence also involves the ability to carry on learning – self-directed study. If you want to be any good at what you do you must have independent motivation to keep on top of what is happening. You need some basic broad structures. Without these you could be doing anything you like. Looking at very old reports with subjective comments, no data, no information, no goals, no evaluation reminds you how much care you need to take to present information in an objective manner.

Any further comments?

None

How do you encourage students to use their practical experience to develop professional competence?

Students need to develop a sense of responsibility for their own practice as soon as possible. Students spend time with other professionals, and they are given responsibility for keeping their own case notes and their own reports up to date. Many of them don't seem to see this as part of the job. They see it as something you make them do, but they don't realise it is a huge part of the job. Also, the first posts that people go into are so busy that if they don't have organisational skills, time management for example, they will flounder. They get very fixed on 1:1 work with clients and their analysis. They like that and don't process the rest of the demands of the job – sending out well constructed letters, phoning people in a professional manner. All HEI's need to work with clinicians to make the students' expectations as realistic as possible.

There are some students who appear to lack empathy. They can create mayor difficulties if you have a client who needs particularly sensitive handling, but the majority are not like that. Students need to self evaluate.

Any further comments?

We use videtaped sessions, not only for gaining client information, but also to look at students' interaction, manner etc.

How do you make decisions during a therapy session?

I have an underlying skeleton of various possible routes a session might go and the actions I would take if particular types of problems arise.

I have an outline of what I would like to achieve in the session, so I will start the client off within that structure. Once they have started, it depends on how they respond to the task. If they are doing well, I will more or less follow the route I have chosen. If not, I will consider whether it is because of the task, some external issue, or the wrong therapeutic approach. I question if it doesn't work, why not. I will then relocate and come at it from a different angle, or if necessary stop and take a completely different route if there is a higher priority for the client at that time. You need an idea of where you want to go (the map), you are aware of the off-routes but you don't necessarily consider those until you present the task. If the task goes well, you can follow the route, if not you need to think laterally and chose the best alternative route.

I am a visual person and I think this is why I think in this way. I like things to be clear with an initial idea of where I will be going in a session.

When you begin you have to have alternative tasks higher and lower then your target. Students also need to remember to keep checking the client and not just the task. You need to ensure the client is comfortable and happy within the task.

Is this decision-making intuitive?

I don't know. You can create a therapist if the basic motivation is there. But at 17 do you know you really want to do the job.

My instinct is that I think there probably is some intuition, but I can't quantify or measure this. I know exactly what I think a student needs to be really good, but if I had to sit down and say this is why and this is how, I couldn't sit down and write it.

When I was studying there were people on my course who were great academically, but who couldn't interact with other people, including clients.

Any further comments?

None

What do you do if a student session is not going well?

Unless it is distressing the client I don't intervene, because students need to learn. So long as the client is not aware, I won't even intervene once they have finished the session – I get them to evaluate themselves. Then if they have identified the problems, fine, if not I will pick on examples of what the student or client did and ask how that may have been done differently. You need to be careful as students can be intimidated. They need to be allowed to make mistakes so that they can learn.

When do you discuss things with the student?

Before a session I give students an outline of who is coming in. If they are seeing the client regularly I ask them to do a plan of their session and their aims. After they have seen the client I try to give them time to write down what has happened – to reflect on the session and consolidate the information. (This is not always possible immediately after the session if the clinic is busy). I don't make them write the case notes immediately, but they must do it before they go. I then ask them if they want to discuss

the session immediately, or later. If they say after, that is fine. Sometimes they don't want to go over the session immediately. If they say they want to wait until after the next one we do, so long as they have fresh notes immediately after the session. I will also note down, subtly, anything I want to draw attention to. It is very difficult to write during a session as the clients notice everything. Of course there are also issues of getting consent if you want to video, and you have to make sure both the client and student feel confident, not anxious, threatened or bullied.

Any further comments?

None

What could we do to make clinical education more effective?

Students being told to reflect a lot (this already happens).

I like the idea of peer placements because it is less intimidating for students and they learn a lot. They support each other. They can do videos and show each other videos.

The new degree locally has adopted all these things, and that is good.

It would be good to look at recruitment and selection and improve early identification of people who are not strong.

Another specific approach may be to enable students to see clients at home very soon after they enter the course. Perhaps someone a couple of years post-stroke, so that they could see the real person in their own environment, not just as an example of a disorder. Even going out with a district nurse for instance. Then in their minds eye, instead of a text book they have a house with a person perhaps a wife with a social security book. More reality. This might also motivate them more.

In terms of what is missing, I have written down social skills, administrative skills, initiative and empathy. But how you work with that I don't know. If the motivation is there it overcomes a lot of the other problems.

Any further comments?

More practical sessions, blocks and weekly placements from the beginning of the course. More time for 1:1 supervision and for perr evaluation. More feedback on performance throughout.

If you could do one thing to improve clinical education over the next 5 years what would it be?

In first year, having something which brings the whole thing together, going to a parents home with a severely disabled child, or someone post-stroke. It would give a picture, and help to give students what they lack, which is an awareness of why they are really there, and what the job is really like. Not necessarily hands on, or even SLT, but something which raised their awareness of impairment, disability and handicap and how these affect someone. I'd get students out sooner.

The bottom line is that the client and his or her needs is central to the job.

Any further comments?

None

Appendix 7.3:
Interview transcript respondent ST96

What is the purpose of clinical placements?

It seems very obvious that you should have clinical experience before you are qualified. It would be really difficult if you qualified without ever being in a clinical situation, then suddenly be expected to run a clinic. It's hard to get the chance to observe in clinic before you get onto a course although lots of courses expect you to do that. Speech and language therapists aren't keen on being shadowed by someone who has not even done their A levels yet. So being on the course is the only time you have to get clinical experience before you qualify.

It's important to see how a therapist works professionally, as well as knowing all the theory, to apply it. To see someone who has been through all that and worked for a number of years means you can see what you are aiming for.

It helps you to work in a team as well. Working in a team with other students is very different from working in a team with other professionals, e.g. occupational therapists, physiotherapists.

On one placement the speech and language therapist worked with a number of different professionals. It was useful to see how you are expected to interact with them.

Placements also let you see the paperwork – e.g. referrals, file management, discharge. In a clinic you can see people doing that as well as the therapy.

It doesn't mean you are going to model yourself on any one professional, but you get more of an idea of what you are aiming for. As a student you don't know what it is like to be a professional in a clinic, giving therapy and being paid. It is easy to lose sight of the fact that you are going to finish and go out to do the job.

Placement gives a good base, so long as you see enough different clients to see how therapy is carried out. Lots of the course is theory. When you actually see a therapist doing a session you can see how the theory is applied (e.g. to a phonology case, or an articulation case). You can see how it progresses and how decisions are made. It's really useful.

Do you enjoy your placements?

I've got a huge amount out of the most recent placement – I'm still buzzing about it. My first two placements were aphasia and then phonology. They were both 'baptisms of fire' because we didn't know what we were doing till we got in there.

This one was with autism. Even before I went in, it was such a challenge and so interesting. We hadn't done lectures before we started. The supervisor was amazing. She did lots of example therapy. She was really helpful. She gave me every possible chance I needed to find out things and practice therapy. There was no stone left unturned. She was a very good model. This is what I would really like to be like.

I was really impressed with the organisation. Children were split into groups by ability. It was really interesting to see how wide the spectrum of autism is.

On other placements I learned a lot about my abilities, but didn't really enjoy them. Everyone found the first placement very hard. It was all so new. I'm really glad we did it early in the course (other students started placement much later). The first placement was in aphasia. I didn't know what I was supposed to be doing. The supervisor was really nice, but I didn't know enough. So when she talked about a speech processing model I didn't understand what she meant. So I had to learn all

that. Then later when we did it in University it clicked. It would have helped to have some theory first. The second placement was better because we had covered phonology and articulation so I was better prepared. The placement was let down because the supervisor was not very good. She was too laid back and didn't push me. Also, the client I had to work with had been having therapy for years and I couldn't see how what I was doing would make a difference if all the years of therapy had had so little impact. The whole point of practising therapy is that you are making a difference.

Any further comments?

None

How do you define clinical competence?

The clinic reports have the word 'competent' all over them. By the end of third year you are expected to be a competent clinician and build on this in 4th year. The areas where you have to be competent are assessment, deciding on prognosis, planning, case management, (not discharge) working with other people. You have to be competent in all the areas to be a completely competent clinician.

You need to be confident in decision-making but not closed to other options so you can think about other ideas you may not have heard of before. Open to other people's suggestions about how things might work. Being able to establish rapport with clients and carers and other people you work with. So you are not a difficult person to get on with.

I don't think you can teach a person that. You can teach a person how to interact better – you give therapy for that. But whether you are an approachable person or not is difficult.

Is a therapist born or made?

Both. You can be naturally skilled in some types of things and then learn other things as you go along. Otherwise you wouldn't have a course. There has to be something there in the first place to build on. Looking at our year, we are all similar kinds of people. I think that tells you a bit about the type of people you get.

You keep on learning after you qualify. A lot of the course is theory and as a student, even though you have clinical placements and you see a few types of cases. Once you qualify you will come across a lot of cases you won't have had any contact with. I don't know how long it will be, but certainly years. You will still be learning. And not just in cases you haven't seen before but how you are going to work and organise things. You will get into your own way of doing things and deciding how to assess. You will get quicker once you have practice.

The clinic report forms are quite hard because often there are things on the list which you haven't exactly done – you have done something different instead. And sometimes it's difficult to say if it is there or if it isn't. You can't say that you are not competent if you haven't had the chance to try. You get more out of the clinicians comments than the "competent/ not competent" dichotomy. Comments can give you pointers on what to do next.

Any further comments?

None

What helps you to relate theory to practice?

I tried to think about my placements to answer this. On the phonological placement I had the theory and I didn't apply it. I thought it was the fault of both myself and the

supervisor. I tried to work out why I wasn't doing it, because I did relate theory to practice in the most recent placement. Mostly it wasn't theory from lectures, lots was things I'd read or been told.

I thought about the processes that lead to applying theory. Lots of it is how things are presented in lectures. Lecturers go through the theory really well, so you are presented with it clearly, often you are given an example (a case). Then at the end you get a resumé of what they actually did with the case, but that is often really hurried or just missed out. That is a shame, as it is really useful to see how theory has been applied to the client.

It would work best for me if I saw an example of someone doing therapy which relies on that theory, so you can see how it all links in. It would be on video, or in a clinical setting. Then going on to do it yourself.

I like to be guided, though some other people don't. I like someone to say – okay, in therapy what kind of theories are you thinking about that you have been taught? I like being guided to think. I like some structure, but a light hand on the tiller, so that I can make my own decisions.

How do you define theory?

I think of theories – e.g. models for aphasia. There are theories about the types of therapy you can give. Things you pick up from clinic. After my last placement I think I have got a theory about my own therapy. Until I was asked why I had done things I was really unaware of it. I did things subconsciously and she made me more aware of it.

For my first couple of sessions I just observed because I get so much from that. They were in a particular room, and I would sit but not interact too much but I had a chart I'd drawn up with cognition, expressive language, play and such things. I'd make notes on all of them. Then the therapist asked me what I got from that – and she drew up this big chart of things – and I thought "wow, I observed all that!" I'd been far more organised about it than I thought I was.

Sometimes its important to have someone to tell you that you know.

Any further comments?

None

How do you make decisions during a therapy session?

Two examples. First is an assessment unit. I had one child I'd seen for about five weeks and I decided to see him with another child as they worked well together. I had an extensive session plan, with lots of flexibility because I wasn't sure what would happen. There were two big decisions I was conscious of making. One was to do with each child. We had done a number of brief activities because one child had a short attention span and I wanted to keep him interested. At one point the other child got very agitated and didn't want to be there. I had to decide whether to take her out or keep her in and persevere. I could tell by the look on her face that I had to take her out. That just took a second to make that decision.

With one activity the other child hated – I could tell by his body language, facial expression and how he started interacting – it was very different to before. I thought 'right, we're not going to get anywhere with this one', so I stopped it and did the other two activities. That also took a couple of seconds to sort out, just testing the water with him.

If I'd tried to do that session at the very beginning, the decisions would have taken a lot longer. I wouldn't have been able to read such a lot from just his non-verbal communication. I wouldn't have known them both or observed them both. But it went really well.

Is this intuition?

I don't know. The therapist talked about it afterwards. I was keen to know if I'd make the right decision. When you are a student you are aware that you might make the wrong decision. You think that all other professional know they are doing the right thing. So I always ask afterwards – was that the right decision? Was it the right thing to do? In another assessment session I'd stopped a test because it wasn't going anywhere and it was upsetting the child. We'd only been doing it for 10 minutes – but I couldn't ask the therapist during the session if it was the right thing to do, so I just did it. It's a lot to do with how much you know about your client and whether they are getting anything from it. You always need an escape route – something else to do. I don't know whether that is intuition. I think you do learn it – you must do, but its something you stumble into knowing. You don't make an active – "1-2-3 this is how you make a decision".

Any further comments?

None

Describe the characteristics of you most memorable supervisor.

Good supervisor – she spoke clearly, not slowly, but in a controlled manner. That was to everyone. It was obviously her good way working. Every sentence she said made perfect sense. She never seemed to stumble in her words. She seemed to know what she was going to say and then say it.

She didn't go over my head. She knew what level to talk to me, or judged it by checking how much I knew and started me off there. She was really interested in how I was doing. She made certain that she did a student learning contract with me, she knew what I was aiming for and what I wanted to get out of the placement. She knew what I was expected to do in my practical assessment. She made sure I had enough information, gave me a book to read, and was always available to give help if I needed it. She was a practising therapist with lots of other things to do, but she still made the time.

She was brilliantly organised – she had files for everything and bullet points for what we were going to do.

If I asked a question, even if she had to go to something else, she never seemed rushed and she would answer just as calmly. She'd show me how she kept a really good diary and all the other paperwork. She never told me what to do, she just guided me in the right direction. She gave brilliant feedback. It was constructive and positive even when she was suggesting how things could be done better or differently. I'd love to duplicate her so that every student could have her.

Any further comments?

None

Is there a difference between education and training?

I related this to the theory-to-practice question. Education is what you get in lectures and books. Training is what you are doing on placement, when you are applying it. But I suppose you are being educated while you are training. The last placement was

both education and training "educational training"! The word 'education' conjures up the image of being in a lecture, while training is practical, but I think they do overlap.

Do you get enough practical?

I'd love to do more. You could start placements in Year 1, shadowing and being able to observe before you "do" therapy. In our first year there was lots of heavy theory but nothing about therapy. Then there was a short block in the summer, based in a speech and language therapy unit at home but we didn't have a chance to talk about it. We kept a diary and were supposed to do a presentation but it was never followed up at University. It would have been better to do it earlier in the 1st year.

Do you want more education?

Well, yes, I suppose so, to have a chance to see it all worked before you were expected to work it. But it is very unrealistic to think you will see every client group while you are at University.

Any further comments?

None

What could we do to make clinical education more effective?

Using clinical cases is a step forward. Everyone hates role play and standing up and giving presentations, but it is a good way of learning.

Seeing clinical settings as early as possible on the course, and having the chance to get clinical experience before you start University would be good. It would help to avoid people dropping out because they don't know what speech and language therapy is about. It's difficult to find out about it before you get onto a course.

In my last placement I was videoed all the time. On previous placements I knew I was being videotaped, but that was not always watched. Bothering to watch myself on video was a chore. But this time I had to change the video from one video to another and I had to watch it. And it is amazing how much you hadn't realised what had happened. So you learn a lot from watching the session when you are not actually running it. Videoing and watching the videos is really useful.

A 2-way mirror is useful too.

Any further comments?

None

If you could do one thing to improve clinical education placements over the next 5 years, what would it be?

Having enough and as good clinical placements as possible is very important. Having clinicians who are completely committed to students – enabling them to get as much as they can from the placement. If you have a supervisor who isn't interested it almost cancels out the point of the placement.

The other thing is possibly to increase the lecturers' awareness of the clinical relevance of some of their lectures (e.g. epilepsy, or hydrocephalus in Neurology). We would have liked an example case which included the neurology and speech and language problems. The anatomy lecturer always related the theory to our work.

Any further comments?