Situational Teaching: Meeting the Needs of Evolving Learners

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Clinical instruction in athletic training education programs has recently become the focus of much discussion and debate as a result of educational reform in the profession. Educational research related to clinical instruction in athletic training has undergone a corresponding increase.

This article proposes a model of clinical instruction that is based on the developmental levels and learning needs of the students. We examine existing models of clinical instruction and explore the sequential development of clinical learners. The proposed clinical-instruction model is driven by the developmental stages of the clinical learner, and the existing models are examined within that context.

Key Points
Clinical students progress from an initial stage of high dependence on the clinical instructor to a stage characterized by less dependence and the need for some autonomy.

Existing models of clinical learning provide direction in organizing and structuring clinical learning, but few address the changing learning needs of clinical students.

The situational-teaching model is based on Blanchard’s Situational Leadership II model, which directs teaching behaviors based on the developmental level of the person being supervised or taught.

Key Words: clinical instruction, instructional models, situational leadership

Existing Models of Clinical Instruction

There are clinical-instruction models that directly reflect the changing nature of health-care services. Mundt (1997) presents a model that uses the managed-care network through which many health-care services are now provided. In this model students are assigned to specific cases or patients. A student follows a case from inception to resolution within the managed-care system. This model is unique in that it is driven completely by the nature of the clinical setting. The strength of the model is that it prepares students for a particular work setting.

The integrated model described by Mundt (1997) is similar to that used by many athletic training education programs. Athletic training students are usually provided the opportunity to be involved with a case from inception (initial injury) to resolution (return to play) on the premise that this is what will be expected of them in the clinical-practice environment.

The integrated model assumes that students possess sufficient knowledge and skill to ensure that the experience is educational. No provision is made for students with varying knowledge and skill levels.

Problem-based learning (PBL) is as much a methodology as it is an instructional model. PBL is driven by predetermined learning outcomes and specified course content. The specific learning outcomes and course content direct the selection or development of clinical problems, or cases, that require students to use their newly acquired knowledge and skills. Albanese and Mitchell (1993) indicate that PBL is superior to traditional approaches in developing critical-thinking skills. The essence of PBL is that it is driven by predetermined objectives and course content. Although PBL functions well in integrating didactic and clinical content, it does not distinguish between first-year and final-year clinical students.
Lenburg (1999) bases the competency-outcomes and performance-assessment (COPA) model on clinical competency. Identifying general skill areas and subgroups of clinical competencies associated with those skill areas is the first step in implementing the COPA model. It should be noted that each clinical competency identified is believed to be essential to the modern practice of the profession. The selected clinical competencies are then stated as practice-based competency outcomes. Ultimately, the outcomes must be assessable in an objective and measurable fashion.

Although the COPA model is extremely complex, it has many strengths. It yields readily to application in athletic training education because an established group of clinical competencies already exists. COPA incorporates both summative and formative assessments and addresses the developmental needs of learners, making it stronger than other models. The COPA model, however, like most other models, functions as though competency were a singular event that is attained one time and documented one time.

Student-centered learning principles have been used as the foundation for clinical-instruction models. Baxter and Gray (2001) used such principles in an attempt to foster deeper learning in clinical students. A key element of this particular model is a lesser degree of instructor supervision. Instead, students placed in pairs began to rely more heavily on their peers for instructional feedback. It must be noted that this model, as presented, was implemented with upper-level students. Students in this project reported high degrees of dependence on their peer partners and a sense of collegiality that was very beneficial to deeper levels of learning. Extensive use of learning logs or journals is incorporated in this approach. It is anticipated that students have preexisting knowledge and skill levels that will allow them to function within this model.

The student-centered approach involving extensive use of peer tutors is better suited for advanced clinical students. This model would be inappropriate for younger students because of the decreased levels of instructor interaction and the expectations for reflective thinking expected of more advanced clinical students. The role that collegiality plays in the success of the model is notable and further supports the unique characteristics of advanced clinical students.

Allied health-care education programs often use formal laboratory settings for the initial teaching of clinical skills. A model described by Infante, Forbes, Houldin, and Naylor (1989) employed this method of instruction. Students first learned the theory element of the skill in a didactic setting and then practiced the clinical skill itself in a laboratory setting. Infante et al. indicate that students were able to establish a working relationship with their instructor-supervisor in the clinical setting after adequate instruction in the laboratory setting. Students also indicated that the working relationship with the clinical supervisor was extremely beneficial in their learning process.

**Progression of Clinical Learners**

Benner (1984) suggests that clinical competency exists on a continuum. Novice clinicians are guided by a different thought process than are expert clinicians. In addition, novice clinicians need different input or stimulus than do expert clinicians in order to function effectively. Novice clinicians are very rule dependent and usually rely on protocol and guidelines, whereas expert clinicians might rely heavily on experience and intuition. In this framework, students progress from novice to advanced beginner and then to competent. On becoming entirely competent, a clinician can advance through a proficient and then, ultimately, to an expert level.

The competence continuum can yield much information about the learning process. If this continuum is applied to an entry-level educational program, it becomes apparent that expert levels of competency will not be attained. In fact, Benner (1984) believes that years of practice in the clinical setting are required to reach expert status. Stritter (1982) followed a similar process in developing the learning-vector model. Stritter's model contends that over time clinical students become more self-reliant and focus less on their clinical instructor (CI). Clinical students shift from thinking in terms of abstract concepts to thinking about how the immediate situation compares with past experience. Both experts agree that learners demonstrate changing needs as they progress through clinical education. The situational-teaching model is focused on the changing needs of clinical learners.

**Situational-Teaching Model**

This model is based on the leadership model proposed by Hersey and Blanchard (1968) and later refined by