Making a Clinical Climate in the Classroom

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A dvanced Concepts in Occupational Therapy is an undergraduate course that helps students make the transition between academic and clinical expectations. The course yields three credits and is team taught by two instructors. Our aim is straightforward—to create a clinical climate. The course offers tasks that include (a) clinical reasoning from many frames of reference, (b) treatment planning, (c) documenting in various formats, (d) interacting in simulated treatment situations, (e) participating in mock team meetings, (f) teaching small groups, and (g) debating ethical issues. Tasks such as these characterize many other senior-level courses both in this program and elsewhere (Field, 1992; Higgs, 1990; Neistadt, 1987, 1992; Neuhaus, 1988; VanLeit, 1995). The tasks themselves are thus not the subject of this discussion so much as is the process that the instructors use to establish a clinical climate. Although this course is singular, it illustrates a method that can be used throughout any occupational therapy curriculum to better prepare students for practice. This article will discuss (a) the meaning of the term clinical climate, (b) the rationale for creating such a climate in classroom sessions, (c) the methods used to establish this climate in one course, and (d) the responses of undergraduate students to the approach.

The Meaning of a Clinical Climate

The word climate can be defined as the prevailing temper or environmental conditions characterizing a group or period (Merriam-Webster's Collegiate Dictionary, 1993). By extension, therefore, the phrase clinical climate conveys this meaning: the prevailing temper or environmental conditions that characterize the clinic.

Differing climates affect personal functioning. This phenomenon is well portrayed in the novel Memory Board (Rule, 1987). One character experienced her arthritic condition while in Vancouver: “Diana labored back through the house and dressed as quickly as she was able, hearing her own sobbing grunts as if they came from somewhere outside herself” (p. 68). A marked change in her condition occurred in the desert: “Dry and warm and faintly dusty, it had already worked its magic on Diana’s joints. She could turn her head farther and more easily. There was no pain in her shoulders, and her knees did her easy bidding” (p. 214). For Diana, the desert climate was empowering.

Emotional, social, or intellectual climates—whether nurturing or hostile, unnerving or dull—can evoke distinct behaviors. For this reason, occupational therapists have advocated not only the most empowering environment for patients, but also a climate of caring in which
"caring means being true to our humanistic and functional heritage" (Yerxa, 1980, p. 532). In educational practice, caring and empowerment seem equally important. In her Eleanor Clarke Slagle Lecture, Jantzen (1974) said of students:

We depend on them to keep the field alive and lively and by their performance as practitioners, to realize some of our dreams, hopes, and visions for the field. They depend on our experience, the knowledge that we have gained, to guide them into becoming competent and confident occupational therapists. So far as I am concerned, that is what the role of educator is all about. (p. 78)

Students preparing for clinical practice need the kind of guidance that will let them act in a way that is (a) self-directed, (b) conscientious and ethical, (c) thoughtful and considerate, (d) resourceful, (e) adventurous, (f) responsible, (g) holistic, (h) prepared but flexible, (i) spontaneous but focused, (j) confident but open, and (k) tolerant of ambiguity (American Occupational Therapy Association, 1991). Given these expectations, we aim to create a climate that will evoke a similar way of being.

Introduction to the Course

Advanced Concepts in Occupational Therapy is a lecture and laboratory course. Students participate in a weekly 2-hour lecture with 40 to 45 of their peers and a 2-hour lab in smaller groups of 15. On the first day of class, they hear from us that this course aims to simulate the clinic, that they have already learned much, and that this course will prompt them to integrate that learning.

Students are asked to view their relationship with us as analogous to that which they will have with their clinical supervisors. They are told that in the process of preparing them for clinical realities, we will ask them to reflect, synthesize, think on their feet, take risks, be seen and heard, give and get feedback in public, use a realistic pace, articulate their rationale clearly, and assume personal responsibility for learning. They are reminded that they have already met similar demands, especially in the laboratories that preceded this course, but that the expectation to function as clinicians will dominate this course.

To lighten the tone but reinforce the challenge, we ask students to consider and decipher several abstract graphics that convey the messages "no spoon-feeding," "thinking on the feet," and "hard-nosed." Turning then to the course syllabus and schedule, we explain that in the absence of assigned readings, students should read materials on the topic scheduled for each session. We refer students to a list of the kinds of tasks that will structure the course: casework, debates, role plays, interviews, evaluations, and team meetings. Students are told that if any in-class experience leaves them confused or curious, they should assume the need to read further and then question either of us.

Discussion about the course then moves to the percentage of grades allotted for class participation and for course projects, most of which students complete during class. After this introduction, we operationalize the climate with a simulated clinical activity. For example, we have used a videotaped simulation of a patient attempting to perform a self-care task, asking students to articulate hypotheses about what the problem might be. Students leave this first session with a good grasp of what to expect at subsequent meetings.

Strategies That Create the Climate

Nine methods structure the making of a clinical climate in this course. We regularly (a) select random responders, (b) demand full sentences, (c) press for clarity, (d) expect active listening, (e) time assignments, (f) spring surprises, (g) impose ambiguity, (h) invite disagreement, and (i) give feedback openly. Choosing these methods because we thought them pragmatic ways of helping students, we found it interesting to later learn that some of these methods appear in the literature on critical thinking (Paul, 1993).

Select Random Responders

In typical classroom sessions, most instructors ask questions after which students raise their hands or offer responses. Exchanges within the clinic differ: Someone asks a therapist a question, and the therapist must respond.

To bridge classroom and clinical expectations, we select random responders from an envelope filled with the students’ names. Because the students know that their names appear several times, they realize that they might be chosen more than once during any session. This random selection forces students to formulate an assertive response. We encourage students to ask for clarification or repetition if necessary and to state what they know while owning their uncertainties. Associated with this strategy is the hope that students will derive confidence from their capacity to respond and achieve comfort in declaring a need for more knowledge.

Demand Full Sentences

Classroom instructors tend to let students use one-word responses. Take, for example, the multiple-choice form of test wherein students supply fill-in answers to the questions posed. Within this format, an instructor has no way of knowing what a student means to convey from cryptic responses. In the clinic, one-word communic-
tions may occur, but clinicians usually respond to inquiries that require full-bodied explanations.

We affirm the clarity of full sentences and then gently cue students to elaborate whenever one-word responses occur. Cues may take the form of “Tell me more” or “How about a full sentence?” or simply a two-handed gesture signifying the need to stretch the idea out. Before long, students cue one another good-naturedly. Associated with this strategy is the hope that students will become articulate in formulating and communicating their thoughts.

Press for Clarity

Classroom instructors tend to rephrase the statements of students, sometimes embellishing original responses to either shape a student’s next attempts or enhance the idea for the rest of the group. In the clinic, however, a therapist is generally held accountable for lack of clarity, earning puzzled looks or pointed questions.

We refrain from embellishing unclear comments. Instead, we press for clarity. We may pose a mildly challenging follow-up question that exposes the student’s ambiguity or imprecision. We may ask, “Are you saying that (and we paraphrase)?” Or we may simply say, “I am not certain of your meaning.” Students are thus pressed to clarify. The hope of this strategy is that students will produce the restatements and reformulations that more closely characterize exchanges one would have in the clinic.

Expect Active Listening

In large classroom sessions, students sometimes listen less when others have the floor. In the clinic, therapists either learn the value of listening to other members of the team or experience the consequences of failing to do so. To enhance collegiality in the Advanced Concepts course, we ask that students listen to one another.

One of us may begin by eliciting a position statement from one student. When that student responds, we may select another student to paraphrase the position and then offer points of agreement or disagreement. A third student might then be asked to either respond to both peers or take sides. Generally, discussion gets pretty animated at this point, with most class members eager to participate. The purpose of this strategy is to encourage students to see how much learning follows active listening.

Time Assignments

Typically, students complete assignments at home where they allot an unspecified and sometimes inordinate amount of time to the task. In the clinic, most projects are due within short time frames dictated by practical matters: Someone else needs the chart; a client is due to arrive in 15 minutes; a colleague just left sick. Not only must clinical work get done well, it must get done quickly and in places that may be distracting.

To simulate this clinical reality, we assign many tasks for completion during class. The assignments are timed. Students may be asked to write two patient goals in 5 minutes or write a progress note in less than 12 minutes. Generally, time limitations become more intense as students show increased comfort with the demand. We hope that this strategy will encourage students to produce good work in clinic-like conditions.

Spring Surprises

Often, students are lulled by the regularity of events within lectures: They sit and listen as their instructors speak, demonstrate, or use technological variations on these two teaching modes. In the clinic, a typical day offers a number of surprises to which a therapist must accommodate with grace. An administrator may arrive unexpectedly; a patient may cancel; a supervisor may delegate a task.

Students experience several activities at each class session, none of which gets advanced billing, so as to simulate the unexpected nature of events in the clinic. The course schedule alerts students to the topic planned for any given session—casework from the Model of Human Occupation (MOHO), for example. Students know their need to review the model before class. They do not know whether they may be asked to present a care plan or conduct an interview or evaluate a patient performance from the perspective of the MOHO. The element of surprise keeps students alert and motivated; we hope that students will respond with equanimity to a number of changing demands.

Impose Ambiguity

Students often press their instructors for the “right answer.” Their frustration runs high when they hear that a singular response is rare in the clinic. Traditional tests often reinforce a student’s expectation that one correct answer prevails. In the clinic, the individual character of each patient and practitioner and the frames of reference and guiding philosophies of each setting are but a few variables that will determine differing but viable actions. A therapist gains tolerance for the ambiguity that accompanies a range of alternatives that depend on context or individual circumstance.

In Advanced Concepts, the team approach to teaching is used to good advantage, with each of us sharing dif-
different views. Students see many ways of thinking or doing—six different formats and forms for writing a progress note, for example—and have ample chance to critique each. When a response or approach is offered, students are asked to think of and discuss another. We hope that students will welcome ambiguity as they explore the parameters for determining acceptable actions.

**Invite Disagreement**

If ambiguity is frustrating to students, conflicting information is downright vexing. Classroom instructors often select synchronous themes, offer summaries that give closure, and reward harmonious exchanges. Although synchrony, coherence, and harmony are valuable, they may suggest to students that conflict is rare in practice. In reality, therapists often hold healthy differences of opinion and a measure of comfort with conflict.

We seek assertive expressions of differing views; we invite and model disagreement. Many in-class assignments press the students to debate and disagree, to take one position and then argue its opposite, and to state the perspective that frames the position. The hope of this strategy is that students will greet conflict not as a threat, but as a chance to see a bigger picture.

**Give Feedback Openly**

Most classroom instructors respect the feelings of their students by giving feedback privately: Grades are kept confidential; professional behaviors are discussed behind closed doors; internship evaluations are shared privately. But when students get to the clinic, they face open and unsolicited critiques from many persons, whether patients, peers, or supervisors.

To prepare students for ongoing and public feedback that is both negative and positive, we openly comment on the behaviors that might elicit comments in the clinic. Students may be told in larger groups that their voice volume is low or their speech rapid; they may also be told that their tone is assertive or their touch empathic. They will hear that a response is imprecise or that a performance is creative. They will critique one another and get feedback on how they give feedback—all within a climate of caring. We hope that this strategy will help students to accommodate to the feedback that accompanies practice.

**The Students’ Response**

Students in this setting have opportunities to rate each course and each instructor through formal evaluation at the end of the last class session. All handwritten responses are typed by staff members in the Office of Academic Affairs so that a student’s anonymity will yield forthright commentary. Feedback from students enrolled in Advanced Concepts has been overwhelmingly positive. A sampling of positive responses follows verbatim:

- The Socratic teaching method is excellent. Students [are] not allowed to answer without thinking about what they are saying. [*The fact that no assignments or homework were*] given was excellent in allowing students to be responsible for learning and taking responsibility.
- I learned how to be a more confident person. I think I have also grown to be more open minded.
- I thought that everything that we have learned was tied together in this course.
- Even with no books, tests, or handout packets, I learned more from this course and its instructors.
- This course helped me to put everything together.
- The use of immediate feedback was very helpful.
- I liked the fact that it was so interactive and that you processed problems.
- Fantastic class. Keep it up.
- Excellent course! I’m confident now!

It seems apt to also include the more negative comments:

- Initially, I felt uncomfortable with the in-class assignments in front of peers and the random name calling [sic]. However, I now see that both have helped me to think on my feet. I feel that this class has prepared me for the working world.
- The assignments [as written on the course schedule] could have been explained clearer [sic], but it was the element of surprise that kept the anxiety level high and the course interesting.
- While I understand the reason for the class participation grade, I sometimes feel I had to speak when I really had nothing to say or someone had just said what I was going to say.
- I use the relevance of the course, and I know how difficult it must be to make a real-life course, but I wish some of the information could have started earlier.

**Modifications Based on Students’ Responses**

Students have responded predictably—with some anxiety—to the methods we use in this course. Their anxiety is quite clear in the first two negative comments. We now address that anxiety directly in the first session, expressing the hope that some stress in the curriculum may reduce anxiety later. In response to the third negative comment, we now make a strong effort to note the legitimacy of a student’s saying that there is little to add to what has been said. The fourth negative comment has been harder to address because the specific nature of the
complaint about information starting earlier is unclear. We traditionally tell students that this course pulls together previous learning (i.e., information that did start earlier). If this negative comment meant, however, that the process of creating a clinical climate in the classroom might have started earlier in the program, that measure has also been taken.

**Conclusion**

Although this course has not yet been subject to a rigorous examination of its outcomes, a study is under way. Additionally, strong student endorsement has prompted an implementation of the methods used in the Advanced Concepts course in other courses on legal and ethical issues, work and human occupation, management, and basic concepts.

The process used in the Advanced Concepts course forces us to engage in the same kind of thinking on the feet that we ask of our students. Making a clinical climate in the classroom demands energy, flexibility, teamwork, and sensitivity; the course is hard work. But the visible effects of the process make the effort worthwhile. Changes in student performance are almost as dramatic as this tongue-in-cheek act of acclimating:

"One November, a big flock of ducks, oh, about forty or more, landed right smack in the middle of that lake, and while they were sitting there, that afternoon, a fluke thing happened. The temperature dropped so fast that the whole lake froze over, as solid as rock, in a matter of three seconds. One, two, three, just like that."

"Smokey was amazed at the thought. "You don't mean it?"

"Yep."

"Well, I reckon it must have killed them ducks."

Idgie said, "Why...no. They just flew off and took the lake with 'em." (Flagg, 1987, p. 22)

A wonderful thing happens in Advanced Concepts. Students leave the classroom buzzing animatedly. They take the discussion with them. Creating a clinical climate can thus be seen as one way of heeding Jantzen's (1974) call to keep the profession confident, competent, and lively. ▲

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**References**


