Incorporating Evidence in Clinical Education; Barriers and Opportunities in Allied Health

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ABSTRACT
Clinical education is a key component of health professional education. Clinical educators, like clinicians, are increasingly expected to access and apply evidence from clinical education theories to inform their teaching methods and approaches. Purpose: This study evaluated personal and organizational factors that influenced the ability to access and apply clinical education research evidence into clinical teaching in a group of allied health practitioners at one large metropolitan hospital in Melbourne, Australia. Method: A Cross-sectional survey based on a previously published survey of clinical physiotherapists was custom-designed to examine the factors that influence evidence based practices (EBP) of a range of allied health clinicians working as clinical educators in the hospital setting. Results: The majority of respondents were aware of the importance of evidence-based practice to their work as clinical educators. However, their positive beliefs about the value of EBP were moderated by four inhibiting factors: moderate levels of self-efficacy in accessing and applying clinical education evidence; low levels of self-efficacy in interpreting research data; uncertainty with respect to who is responsible for searching, and critically appraising research evidence; and lack of time and organisational priority for such activities. Conclusions: These results highlight a combination of factors, both intrinsic (skills of the educator) and extrinsic (organisational), that impact on the effective application and integration of evidence from the literature to inform clinical education practices. They also provide directions for increasing the use of EBP for clinical educators, including creating clinical education and workplace cultures that value and promote critical appraisal of EBP in everyday clinical education practice and the need for ongoing professional development opportunities in EBP.

INTRODUCTION
Clinical education is a key component of health professional education. It has evolved from a simple apprenticeship model, where students learned by observation and supervision from master clinicians. Recently, more complex models of clinical education have been adopted, which facilitate students to become interactional, reflective and client-centred practitioners. There is a growing body of evidence which underpins the models of clinical education, adult learning and teaching methods. With this growing body of evidence, educational institutions and students now expect supervising clinicians to demonstrate expertise as educators. An integral component of this expertise is the ability to access and apply evidence from clinical education theories and teaching methods.

The ability to access and apply evidence to inform clinical decision-making is accepted as a standard component of clinical practice. Evidence based practice (EBP) encompasses knowledge of evidence including interpretation of its strength or quality, and skills in interpreting such evidence into clinical decision-making. It has two components. The visible one is a type of professional practice (clinical and/or supervision of students) that is objectively based on relevant and appropriate empirical evidence. The underlying and less visible component comprises a set of skills, knowledge and attitudes of individual practitioners.
that are necessary for evidence in its different forms to be actively sought and integrated into everyday professional practice. This paper focuses on the second component. Research about EBP in clinical practice has similarly focused on this second component, examining how clinicians understand and incorporate research evidence into patient management. Factors such as clinicians’ awareness of the need to use evidence in clinical decision-making, knowledge of how to access the evidence, attitudes towards and self-efficacy in finding and using evidence have been found to impact on the application of evidence into clinical practice. These characteristics, termed ‘EBP self-efficacy’, are the perceived ability to undertake activities required to implement EBP. In addition, organisational resources, such as the presence of a library, a resource person, internet access, and managerial and peer support, impact on the implementation of EBP.

In contrast to EBP in the clinical setting, there is a paucity of research that has examined how clinical education research is accessed, retrieved and applied by clinical educators in their work environment. In particular, there is a lack of evidence regarding factors that impact on clinical educators’ capacity to apply evidence-based clinical education literature into their day to day clinical education practices. In clinical education, principles of EBP require clinical educators to pose questions about their teaching practices, to acquire and appraise relevant literature and then to apply it to their practices.

The primary objective of this study was to evaluate personal and organizational factors that influence the ability to access and apply clinical education research evidence into clinical teaching in a group of allied health practitioners at one large metropolitan hospital in Melbourne, Australia. We hypothesised that clinical educators’ self-efficacy in evidence based clinical education (i.e. their ability to use evidence from clinical education literature), would be influenced by similar types of organizational and personal factors that have been shown to be important in clinical practice.

METHOD
Ethical approval for this cross-sectional survey was gained from the Human Research Ethics Committee at The University of Melbourne (HREC 0824407). Data collection took place on a single day (31.1.08). Consent to participate in this study was implied by return of the survey.

Participants and Survey Procedure
All Allied Health clinical educators from a large metropolitan public hospital in Melbourne, Australia, who attended a series of four clinical education workshops, were invited to participate in this study. Three days prior to the first workshop, the enrolled educators were emailed a plain language statement which informed them of the nature of the study. At the end of the first workshop, one researcher (CD) explained the purpose of this study to the educators and invited them to complete a custom-designed survey. Educators were encouraged to complete this survey during the workshop and to submit it in a labelled box outside the seminar room. Participants submitted their surveys as they left the seminar. This procedure ensured that the researcher was blinded to the study participants as well as assuring participant anonymity and confidentiality.

The Survey
The survey was custom-designed to examine the factors that influence EBP practices of a range of allied health clinicians working as clinical educators in the hospital setting. Survey items were informed by the work of Salbach et al., who examined physical therapy practitioner and organizational barriers to EBP for the treatment of people with stroke. The Salbach et al survey was developed from previous surveys that examined EBP beliefs, attitudes, knowledge and behaviours of physical therapists and prior to that, perceptions of general practitioners to EBP. The focus and questions developed for these surveys were highly relevant to EBP research but needed to specifically focus on evidence-based clinical education. Therefore the items from the survey used by Salbach et al., were reviewed by the researchers and were modified, where appropriate, to ensure that each item focused on EBP in the context of clinical education. The draft survey was then piloted on three clinical educators who provided feedback on the content, clarity and relevance of the survey items. This informed minor modifications to the survey and provided some evidence that the survey has face validity. This procedure has been used in a previous publication.

The final survey comprised 37 questions that addressed EBP beliefs, personal skills and resources of current clinical educators (clinical educators who had supervised at least one student in the last six months) (Appendix 1). Items were divided into five sections:

1. Clinical supervision of undergraduate students during the last six months (1 question)
2. Personal attitudes towards the use and perceived benefits and limitations of evidence-based practice in clinical education (12 questions)
3. Educational level and self-efficacy in EBP (3 questions)
4. EBP resources including barriers to EBP (10 questions)
5. Demographic characteristics of the clinical educator and clinical education experience (11 questions)
The majority of the questions required respondents to indicate their level of agreement with a statement on a 5-point Likert scale ranging from “strongly agree” to “strongly disagree.” Other questions, particularly those in Section 4, required respondents to select the most appropriate response from “yes”, “no” or “do not know”.

Statistical Analysis
All data were entered into MICROSOFT Excel 2003. The response rate was calculated as the number of completed surveys returned divided by the number of participants enrolled in workshop. Descriptive statistics were used to summarise the data gained from all sections of the questionnaire. The barriers and opportunities to using EBP in the clinical educators’ work were identified by calculating percentages for the responses on items (Questions) 14-26. Percentage estimations were calculated by collapsing the “agree” and “strongly agree” categories for positive responses and the “disagree” and “strongly disagree” for negative responses.

RESULTS
Respondent Characteristics, Demographics and Experience (11 questions)
From a total of 73 seminar attendees, 66 returned the survey (91% response rate). Of the 66 returned surveys, 13 indicated that they had not supervised students in the past 6 months. Therefore, data analysis were based on a total number of 53 respondents. The average age of respondents was 32 years (SD = 8.5), and 93% (n = 49) of the sample were female. Table 1 summarises the demographic data and characteristics of survey respondents. The largest respondent group were physiotherapists. This reflects the allied health composition in the hospital.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean</th>
<th>SD</th>
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<tbody>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
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<tr>
<td>Average age</td>
<td>32</td>
<td>8.5</td>
</tr>
<tr>
<td>Years practiced (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical practice</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Clinical education</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Division of activities/roles within respondents’ work time (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient care</td>
<td>65</td>
<td>17</td>
</tr>
<tr>
<td>Clinical education</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>Administration</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Service improvement</td>
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<td>5</td>
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<td>3</td>
</tr>
<tr>
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<tr>
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<td>49</td>
<td>93</td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Allied Health Discipline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietetics</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>6</td>
<td>11</td>
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<tr>
<td>Physiotherapy</td>
<td>30</td>
<td>57</td>
</tr>
<tr>
<td>Social Work</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Speech Pathology</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Highest degree gained</td>
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<td></td>
</tr>
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<td>Undergraduate/Bachelor</td>
<td>40</td>
<td>76</td>
</tr>
<tr>
<td>Entry level Masters</td>
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<td>11</td>
</tr>
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<td>Masters</td>
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</tr>
<tr>
<td>Graduate Certificate</td>
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<td>2</td>
</tr>
<tr>
<td>Graduate Diploma</td>
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<td>2</td>
</tr>
<tr>
<td>Hours of work per week</td>
<td></td>
<td></td>
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<tr>
<td>&lt; 20</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>20-30</td>
<td>4</td>
<td>8</td>
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<tr>
<td>31-40</td>
<td>26</td>
<td>50</td>
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<tr>
<td>&gt; 40</td>
<td>22</td>
<td>42</td>
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</table>

N number; SD standard deviation
Personal Attitudes towards the Use and Perceived Benefits and Limitations of Evidence-Based Practice in Clinical Education (12 questions)

All respondents indicated that evidence-based clinical education literature was necessary in their education of students and that they were interested in learning or improving their skills in accessing and applying EBP literature to their work. Seventy-four percent of the respondents (n = 39) indicated that literature about clinical education was broadly useful in their day-to-day supervision and education practice although less (64%, n = 34), indicated that the literature more specifically assisted them in their role and decision making as educators. Eighty-five percent (n = 45) believed that evidence-based clinical education literature improved the quality of clinical education processes and acknowledged the need to increase their use of EBP clinical education literature in the future.

These responses suggest that clinical education literature was potentially useful to their practice as clinical educators. However, only 32% of the sample (n = 17) thought that they should be responsible for conducting their own literature reviews and less than half of respondents (49%, n = 26) indicated that they should be responsible for critically evaluating the quality of literature. A higher number of respondents (66%, n = 35) indicated that it was their responsibility to interpret the applicability of the findings from the literature to their student needs.

Skills in Practicing EBP (3 questions)

Twenty-one percent (n = 11) of participants indicated that they had received formal training in how to search the literature and 55% (n = 29) had received training in how to critically evaluate research literature. Where previous formal training had been undertaken, it had occurred on average more than three years prior to the survey.

Table 2 summarises respondents’ perceived levels of self-efficacy in undertaking EBP activities. One hundred percent confidence in an EBP activity equated to ‘certainly can do’ and 0% represented ‘cannot do at all’. There were moderate to fair (57-65%) levels in almost all aspects of EBP self-efficacy. However, on average, a lower self-efficacy was reported for interpreting the results of statistical tests (45%) (Table 2). It must be noted that the standard deviations for the self-efficacy items are relatively large, which indicates that there was considerable variability in self-efficacy in the sample.

<table>
<thead>
<tr>
<th>How confident are you in your ability to:</th>
<th>Mean % (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Identify an issue in your clinical education practice that requires further knowledge or research?</td>
<td>65 (18)</td>
</tr>
<tr>
<td>b. Effectively search the relevant literature to address a specific clinical education question?</td>
<td>59 (21)</td>
</tr>
<tr>
<td>c. Critically appraise the literature for quality and relevance?</td>
<td>57 (19)</td>
</tr>
<tr>
<td>d. Interpret results of statistical tests?</td>
<td>45 (22)</td>
</tr>
<tr>
<td>e. Appropriately apply evidence from the literature to your needs as a clinical educator?</td>
<td>63 (16)</td>
</tr>
<tr>
<td>f. Continually evaluate the effect of your clinical education practice?</td>
<td>63 (18)</td>
</tr>
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</table>

Access to EBP Resources (10 questions)

Respondents indicated they had a moderately high level of access to evidence-based clinical education material. Fifty-one percent (n = 27) reported that they had access to current research journals; 32% (n = 17) said they did not and 17% (n = 9) did not know. Ninety-three percent (n = 49) of respondents had access at work to research databases which could be searched to identify relevant research evidence. Eighty-one percent (n = 43) had this access at home whereas 67% (n = 36) accessed this through a resource person in their department.

Figure 1 illustrates the top three barriers that affected respondents’ abilities to update their clinical education knowledge and practices. The most frequently reported barrier was lack of time (33%, n = 50), followed by lack of priority from the organisation in which they were employed (21%, n = 31), and an insufficient understanding of, and ability to interpret statistics (13%, n = 20). Other barriers to accessing and applying evidence to clinical education teaching included lack of resources; lack of research skills; poor appraisal skills; inability to apply findings; lack of support from colleagues or a personal lack of interest. In the category of ‘other’ barriers, respondents listed a lack of experienced educators/researchers on staff; clinical education to be only a small aspect of their job; not a personal priority and not actively encouraged. Seventy-seven percent (n = 41) of respondents indicated that their department supports the use of current research in clinical education practice and 11% (n = 6) reported that they obtained financial support from their department to attend clinical education meetings.
Discussion
This study is in part a replication of the study by Salbach et al., which examined practitioner and organisational barriers to the implementation of EBP by physical therapists who treated people with stroke.\textsuperscript{10} We similarly examined barriers to EBP, but in the context of clinical education delivered by a range of allied health practitioners in one hospital setting. A key finding in this research was that the majority of respondents were aware of the importance of EBP to their work as clinical educators. However, the positive beliefs about the value of EBP were moderated by four inhibiting factors:

1. Moderate levels of self-efficacy in accessing and applying clinical education evidence;
2. Low levels of self-efficacy in interpreting research data
3. Uncertainty with respect to who is responsible for searching, and critically appraising research evidence; and
4. Lack of time and organisational priority for such activities.

Factors 1 to 3 can be classified as intrinsic barriers (i.e. barriers that are directly attributable to the clinical educator) whereas Factor 4 is an extrinsic barrier (i.e. one that is imposed by the organisation in which the clinical educators work).

Table 3 provides a comparison between the results of this study and other similar findings in allied health clinical contexts. Our findings highlight the importance of self-efficacy as a factor that impacts on clinical educators’ willingness to access and apply clinical education evidence, There is evidence in the psychology and education literature which similarly identifies an association between levels of self-efficacy and willingness to perform an activity.\textsuperscript{22,23} In higher education, teachers’ understanding of and self-efficacy in various aspects of their professional teaching activities have been shown to shape the specific meanings or purposes they attach to their teaching roles.\textsuperscript{9,24-26} When these findings are applied to the clinical education context, lack of self-efficacy may influence the priority, and therefore, time, that clinical educators devote to EBP. This includes the time required to develop skills in this area and the ability to apply these skills into their everyday teaching role.
In our study, there were low levels of acceptance of responsibility to access and interpret clinical education literature. Only 32% (n = 17) of respondents in this study believed it was their responsibility to conduct their own literature reviews and less than half (49%, n = 26) believed they should be required to critically evaluate the quality of the literature. This dysjunction between clinical educators' acknowledgement of the importance of EBP in their teaching roles and their reluctance to take on responsibility to actively incorporate EBP into their teaching, could be explained by a lack of time to incorporate educational responsibilities and/or a lack of acceptance of the clinical educator role or professional identity as an educator. Clinical educators largely describe their role as a clinical one. This is unsurprising, as the clinical educators surveyed in this study spend on average 65% of their time on patient care activities (and only 15% of their time on clinical education activities). As such, clinical educators are more likely to focus their time and energy on responsibilities associated with increasing their competence and ongoing professional learning in the clinical aspect of their work. These results need to be interpreted with consideration to the range of allied health disciplines represented in this study and the potentially different clinical education models between the disciplines.

The number of participants in each allied health disciplines precluded analyses to determine whether the professional discipline affected the ability to access and apply clinical education research evidence into clinical teaching. Therefore, there is a need for more research that examines how clinical educators in different disciplines perceive their roles and responsibilities and how this perception is influenced by factors such as time, experience and perceptions of professional identity.

Lack of time and organizational priority for EBP activities were identified as barriers in this study. These factors have been similarly identified in clinical studies of physiotherapists and occupational therapists (Table 3). Several research groups have
shown that external factors, such as lack of time and lack of organisational / work place support, influence both ability and individual self-efficacy to apply EBP in clinical practice.5,10,11,15,16,28 It is plausible that this association between intrinsic and extrinsic barriers could exist for clinical educators. For example a lack of time related to clinical educators’ multiple roles as teachers, clinicians and administrators impacts on their ability to develop high level skills in finding, and critically appraising relevant evidence, then identifying how this evidence could be applied to their clinical education practices. Examination of the links between intrinsic and extrinsic factors was not the focus of this study, and it requires further investigation in the future.

Our research also examined the impact of prior training in EBP on clinical educator’s ability to integrate EBP into their teaching practices. It has been hypothesised that different health disciplines may possess differing levels of evidence-based clinical education within their discipline training.13 This means that skills in accessing and applying evidence about clinical education may be variable both within and between different allied health professions. This is important in the context of providing common resources for a range of different health professions and implementing multi-disciplinary education strategies. In our sample, we were not able to investigate whether differences existed between the different allied health professions due to the small number of participants in some of the disciplines, in particular Speech Pathology (n=8), Dietetics (n=6), and Social Work (n = 2).

This study is limited by the specific sample of allied health professions who participated, including the uneven representation of disciplines. The survey instrument was developed and modified from previous surveys and lacked systematic testing of its psychometric properties. Further research is needed to validate an appropriate survey tool and to examine and compare evidence-based clinical education practices in specific discipline groups.

Our results highlight a combination of factors, both intrinsic and extrinsic, that impact on the effective application and integration of evidence from the literature to inform clinical education practices. These factors also highlight opportunities to improve the use of EBP by clinical educators. These include creating a clinical education and workplace culture that recognises clinical education as a distinct professional identity,8 and that values and promotes critical appraisal of EBP in everyday clinical education practice. Early preparation and training of clinicians in their academic careers and studies means they may be more likely to implement evidence-based clinical education once they graduate.5,11 There is evidence which suggests that clinical educators benefit from professional development opportunities.29,30 Therefore, clinician training in the finer skills and understandings of research evidence, e.g. statistical interpretation, may be beneficial as we identified that self-efficacy in these skills to be only moderate to fair. Practical strategies to integrate EBP in clinical education practice may include regular education sessions in searching and accessing clinical education evidence; forming journal clubs to raise the profile of relevant clinical education literature; scheduling journal discussions in staff meetings and developing a web based structure on hospital or workplace intranet sites for the dissemination of relevant literature. These external supports need to be integrated with more explicit role definitions and descriptions for clinical educators to encourage their development and professional identity as educators in addition to their more established clinical practice role. Promoting professional identities as a clinical educator and fostering associated responsibilities are important to ensure that both barriers and opportunities for increasing skill and self-efficacy levels in EBP are recognised.

Schreiber and Stern argue for and aspire to a ‘culture’ in clinical practice that ‘understands research, values and promotes critical appraisal of EBP in everyday clinical education practice. Therefore, clinician training in the finer skills and understandings of research evidence, e.g. statistical interpretation, may be beneficial as we identified that self-efficacy in these skills to be only moderate to fair. Practical strategies to integrate EBP in clinical education practice may include regular education sessions in searching and accessing clinical education evidence; forming journal clubs to raise the profile of relevant clinical education literature; scheduling journal discussions in staff meetings and developing a web based structure on hospital or workplace intranet sites for the dissemination of relevant literature. These external supports need to be integrated with more explicit role definitions and descriptions for clinical educators to encourage their development and professional identity as educators in addition to their more established clinical practice role. Promoting professional identities as a clinical educator and fostering associated responsibilities are important to ensure that both barriers and opportunities for increasing skill and self-efficacy levels in EBP are recognised.

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**REFERENCES**


Appendix
Evidence based practice in allied health clinical education practice: barriers and opportunities

Section 1

1. In the past 6 months, have you been involved in supervision / education of undergraduate students?
   - Yes Please go to Question 2
   - No Please go to question 27, page 5

Section 2

This section inquires about your personal attitudes toward, use of, and perceived benefits and limitations of evidence-based practice. In clinical practice, EBP is defined as "integrating individual clinical expertise with the best available external clinical evidence from systematic research" (Sackett et al, 1996). This definition can be applied to the clinical education of students, whereby evidence regarding teaching methods and theories of education (clinical education literature) is integrated into clinical education setting.

For the following items, place a mark in the appropriate box that indicates your response.

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Application of Clinical Education Literature is necessary in the practice of clinical education/supervision</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Clinical Education Literature and research findings are useful in my day to day supervision/education practice</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. I need to increase the use of clinical education evidence in my daily supervision/education practice</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. The inclusion of Clinical Education Literature places an unreasonable demand on my work as a clinical educator</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. I am interested in learning or improving the skills necessary to incorporate Clinical Education Literature into my clinical education practice</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>7. Clinical Education Literature improves the quality of clinical education processes</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</table>

8. Clinical Education Literature helps me make decisions about educating/supervising students

9. Clinical Education Literature does not take into account student preferences (i.e., students’ learning styles, reported values and preferences for learning)

10. There is a definite divide between clinical education research and clinical education practice

11. Allied health practitioners should be responsible for conducting their own literature reviews to answer their clinical education questions

12. Allied health practitioners should be responsible for critically evaluating the quality of the literature to address their clinical education questions

13. Allied health practitioners should be responsible for interpreting whether research findings apply to their students’ learning needs

Section 3

The following section inquires about your educational preparation and about how confident you are in your ability to access, interpret, and apply research evidence to clinical education challenges. The information you provide will be used to enhance future clinical education support materials and information including the planning of continuing education courses and clinical education resources.

For the following items, place a mark in the appropriate box that indicates your response.

14a. I have received formal training (e.g., workshops, courses) in search strategies for finding research relevant to my role as a clinical educator

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

14b. If you have received formal training in search strategies, please state the year when this was undertaken ____________
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15a. I received formal training in how to critically evaluate research literature as part of my academic preparation

☐ Strongly Disagree  ☐ Disagree  ☐ Neutral  ☐ Agree  ☐ Strongly Agree

15b. If you have received formal training on how to critically evaluate the research literature, please state the year when this was undertaken ________________

16. For each of the following activities please indicate how confident you are in your current level of ability by choosing the corresponding number on the following rating scale:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

- Cannot do at all
- Moderately able to do
- Certainly can do

How confident are you in your ability to:

a. Identify an issue in your clinical education practice that requires further knowledge or research? _____%

b. Effectively search the relevant literature to address a specific clinical education question? _____%

c. Critically appraise the literature for quality and relevance? _____%

d. Interpret results of statistical tests? _____%

e. Appropriately apply evidence from the literature to your needs as a clinical educator? _____%

f. Continually evaluate the effect of your clinical education practice? _____%

Section 4

The following section inquires about the availability of resources and support to promote EBP for your work as a clinical educator.

For the following items, place a mark in the appropriate box that indicates your response.

17. I have access in my department to current research through professional journals about clinical education in their paper form

☐ Yes  ☐ No  ☐ Do not know
18. I have the ability to access relevant databases and the Internet at my department  

☐  ☐  ☐

19. I have the ability to access relevant databases and the Internet at home or locations other than my department  

☐  ☐  ☐

20. A resource person (eg, clinical education leader, librarian, research therapist) is available at my department to assist me with accessing clinical education literature  

☐  ☐  ☐

21. My department mandates the use of current research findings in clinical education practice (mandate is a written requirement)  

☐  ☐  ☐

22. My department provides protected time to conduct literature reviews and appraise the clinical education literature  

☐  ☐  ☐

23. My department provides financial support to attend clinical educational meetings and conferences on clinical education  

☐  ☐  ☐

24. My department supports the use of current research in clinical education practice  

☐  ☐  ☐

25. Colleagues within my department are sceptical of new clinical education literature in the area of clinical education.  

☐  Strongly Disagree  ☐ Disagree  ☐ Neutral  ☐ Agree  ☐ Strongly Agree

26. The following question inquires about the top 3 barriers to updating your clinical education knowledge with new knowledge. Please indicate by ticking the appropriate box the 3 greatest barriers to updating your clinical education skills with new knowledge  

Insufficient time allocation for clinical education activities  

☐

Lack of information resources  

☐

Lack of research skills  

☐

Poor ability to critically analyse the literature  

☐

Inability to apply research findings to my particular students  

☐

Lack of understanding of statistical analyses  

☐
Lack of support among my colleagues in my department  
Lack of interest  
Lack of organisational priority  
Isolation from peers  
Other, please specify______________________________

Section 5

The following section inquires about your demographic characteristics and your clinical education practice.

27. How old are you? __________ years

28. What is your gender?  
   □ female  
   □ Male

29. What is your area of allied health practice?
   Dietitetics /Nutrition  
   Facial prosthetics  
   Music Therapy  
   Occupational therapy  
   Orthotics and Prosthetics  
   Physiotherapy  
   Podiatry  
   Psychology  
   Social work
Speech therapy □
Other (provide name) □

30. What is your entry-level degree for your allied health qualification?
Certificate □
Bachelor degree □
Entry-level Master □
Other, please specify □

31. In what year did you graduate with your allied health qualification? ________________

32. What is your highest allied health degree attained?
Bachelor degree □
Entry-level Master □
Applied or research Master □
Doctorate □
Other, please specify ________________

33. For how many years have you been in clinical practice? ________________

34. How many years of experience do you have as a clinical educator? ________________

35. In a typical week, how many hours do you work as an allied health professional?
< 20 hours per week □
20-30 hours per week □
31-40 hours per week □
> 40 hours per week □

36. In a typical day, how many students do you supervise?
1-2 students □
3-4 students □
37. Please indicate the percentage of your total work time that you spend in each type of activity during an average month

a. Patient care _______%  
b. Research _______%  
c. Clinical teaching _______%  
d. Administration _______%  
e. Service improvement/quality _______%  
f. Other, please specify ___________________________ _______%