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The Effect of Early Contextual Learning on Student Physical Therapists' Self-perceived Level of Clinical Preparedness

Kevin E. Brueilly, PT, PhD; T. Kirk Nelson, PT, MPT; Tamara N. Gravano, PT, DPT, GCS; Penny G. Kroll, PT, PhD

ABSTRACT

Context: Students in health care often describe their feelings of self-inadequacy in clinical skills and report these feelings abate with experience.

Objective: To determine whether early contextual learning experiences can improve entry-level student physical therapists' self-perceived level of clinical preparedness.

Design: A pair-wise comparison of pre vs. post intervention. Survey of students self-perceived level of clinical preparedness before and after a series of three planned small group contextual learning experiences involving the assessment of actual hospital patients.

Setting: Academic institution and associated medical center

Participants: Thirty-nine first-year student cohort in the 10th month of a 36-month entry-level Doctor of Physical Therapy program who had not yet received clinical experience utilizing subjects other than classmates or program associated faculty.

Results: Thirty-three (33) subjects completed the pre and post-survey (33/39) for a response rate of 84.6%. Subjects rated both their own personal abilities ($p < .001$) and the clinical abilities of their classmates ($p < .001$) as higher following the intervention, indicating that students in an entry-level DPT program have improved perception of their own and of their classmates' clinical preparedness when employing hospital patients prior to their first clinical affiliation.

Conclusions: Early curriculum contextual learning in physical therapist education is valuable in improving student ratings of clinical self-preparedness and of fellow classmates' readiness to enter the clinic. Additionally, students recognize the benefits provided by contextual learning.

Introduction

Over the past two decades, the education of a physical therapist has undergone a metamorphosis--moving to the master's level and more recently to the doctoral level education for entry-level practitioners. As was the case with the master's degree in the mid 1990's, the transition to Doctor of Physical Therapy (DPT) is occurring rapidly.¹ Additionally, approximately 17,000 practicing clinicians will also obtain the clinical doctorate degree in 2008 by completing transitional DPT programs.²

The maturing of entry-level degree requirements has led to a perceived shortage of qualified faculty to teach at the doctoral level.³ Facing today's economy of tightening educational budgets, any hint of faculty shortage provides reason for educational programs to investigate best teaching and learning methods to maximize the effectiveness of education. Jarski et al⁴ investigated the perceptions of teaching behaviors among entry-level master's and bachelor's students of physical therapy and suggested that students in a master's program may require different instructional methods than their bachelor counterparts. The question then follows whether this same notion of altering instructional methods should be investigated for the Doctoral student in an attempt to maximize learning outcomes.

Maximizing Learning through "Doing"

Nearly thirty years ago, Edgar Dale,⁵ a teacher-researcher demonstrated that method of teaching has a great effect on retention. Dale explained that learners retained more information when they were engaged actively in the learning process, rather than passively listening to a teacher in the classroom. According to Dale, most persons remember approximately 10% of what they hear, 20% of what they see, 50% of information delivered to them in a combination of sight and sound, 70%

of what they speak, and recall 90% of all information in which the learner speaks and participates in the material being presented. This active learning process of combining reception with participation has been described to be a highly effective means of creating significant learning experiences.⁶ The method of instruction utilizing active learner participation refers to any circumstance in which the student is actually involved in an activity that implements or occurs through the use of what the desired learning outcome employs. For example, if the desired outcome of the learner is to ascertain a patient history through a series of questions, the instruction should include the concept of questions involved, followed by an opportunity for the student to formulate and administer questions in a clinical setting. This same premise is further suggested in the development of skill-based learning. As physical therapy education is known to contain a significant amount of skill content, contextual relevance in learning is suggested to translate to performance improvement.⁷

Learning in context is widely supported by educators intimately involved in educational research and curriculum design.^{5, 6, 8-11} This notion of applying real-world concepts has been said to be key to allowing students to generalize their learning to better solve real-life problems.⁸ In physical therapist education, Plack¹² suggests that abstract concepts are not fully assimilated until the concept is applied in the practice context. Recognizing the importance of active, rich learning experiences, physical therapy educators should strive to provide each student with optimal learning experiences, involving the students' active participation in every instance possible.

Unfortunately, the educational process of a student is not always improved through the initiation of a change that might

be beneficial to learning. The learner and the learning environment are often profoundly affected by external factors.⁸ Despite health educators' best intentions in preparing and attempting to implement contextual learning opportunities, entry-level students have reported high levels of stress and anxiety when subjected to the clinical environment.¹³⁻¹⁵ Although a normal occurrence, symptoms of anxiety must be addressed by educators when the student's clinical performance is affected.¹⁶ These important issues then prompt the question, Is the use of contextual learning beneficial to student learning or is the stress and anxiety counterproductive? A review of the available medical literature from OVID and CINAHL revealed no studies in physical therapy education investigating or describing student self-perception of clinical preparedness. The purpose of this study was to determine whether incorporating early contextual learning experiences into the curriculum of entry-level doctor of physical therapy students would improve students' self-perceived clinical preparedness, thus reducing their own levels of anxiety.

Methods

A pre vs. post intervention survey was used to determine perception of clinical preparedness. A questionnaire consisting of 8 questions was developed by the primary author. A combination of questions utilizing a modified visual analog scale (VAS), questions utilizing the Likert method, and open text responses was employed. The survey asked subjects to self-rate their perceptions of clinical preparedness to practice skills on persons other than their classmates and faculty by rating themselves on a scale from 0-10. Zero was anchored as "not at all prepared" and ten was used to describe themselves as "completely prepared." Using the same question format, subjects were then asked to rate their perceptions of their classmates' preparedness to practice skills on persons other than their classmates and faculty. This was followed by a series of four questions asking the subject to rate how valuable they believe real in-hospital assignments would be to their educational

experience as a physical therapist on a 5-point Likert scale (1= completely disagree; 5= completely agree). The last question was an open text response to allow subjects to describe any other information related to their positions on the usefulness or value of employing "real-life" patients early in the educational process. Following completion of survey construction, two other faculty members with experience constructing survey instruments reviewed the instrument and made comments for revision. Following consensus and revision, the survey instrument was piloted via electronic delivery with two second-year DPT student volunteers, both being interviewed following completion of the survey to determine whether any items were confusing or difficult to understand.

Subjects

An invitation to complete the survey and a hyperlink to the questionnaire was sent electronically to the 39 students that comprised the first-year DPT program cohort at Louisiana State University Health Sciences Center, New Orleans, LA. These students were in their 10th month of a 36 month entry-level Doctor of Physical Therapy program, and had not yet been subjected to clinical experience utilizing subjects other than classmates or program associated faculty. The survey was repeated approximately four weeks later, following educational interventions and clinical experiences involving the use of hospitalized patients associated with the institution. The students were made aware that their participation in the pre- or post-survey was completely voluntary, and that their participation or non-participation would have no impact on the grade received for the course associated with the required learning intervention.

Intervention

In the approximate four-week time frame between the initial and second survey, students were subjected to usual didactic instruction in basic patient management skills and contextual practice involving hospitalized patients. All experiences were carried out under direct faculty supervision, and each patient granted informed consent for the planned student group activity.

Contextual learning activities included medical record/chart review, patient interview techniques, and skills associated with basic assessment techniques. All students were scheduled and performed two separate contextual learning experiences to practice and demonstrate their skills in small groups of 3-4 students per group, involving one hospitalized patient per group per activity. The opportunities incorporated the use of prescreened hospitalized patients within the affiliated University hospital. The contextual experiences culminated in each three-student group performing a complete inpatient evaluation of a hospitalized patient, incorporating the skills of chart review, patient interview, and patient assessment. Students worked together in their groups to accomplish the evaluation, dividing the responsibilities among their group as they chose.

Analysis

All statistical analysis was completed using SPSS version 16.0 (SPSS; Chicago, IL). All responses were evaluated as between groups, comparing pre-intervention survey to post-intervention survey results. Questions requesting a 0-10 response (modified VAS) were analyzed using a paired samples t-test. Questions requesting the 5-point Likert response were analyzed using a Wilcoxon Signed Ranks test.

Results

All 39 subjects completed the initial survey of self-perceived clinical readiness. Following completion of the intervention, 33 of the 39 subjects completed the post-survey for a response rate of 84.6%. Ten subjects chose to answer the open text question in the pre-survey, while thirteen answered this question in the post-survey. A compilation of all survey questions can be found in Table 1.

Significant increases occurred among all four questions related to the perceived clinical abilities. Subjects rated both their own personal abilities ($p < .001$) and the clinical abilities of their classmates ($p < .001$) as higher following the intervention, indicating that students in an entry-level

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DPT program have improved perception of their own and of their classmates' clinical preparedness when employing actual hospital patients prior to their first clinical affiliation. A complete description of pre-post results for all survey questions is presented in Table 2.

Pre to post differences ($p < .025$) were found on all of the questions utilizing Likert scales, indicating that students in this entry-level physical therapy program rate the value of contextual learning experiences involving actual hospital patients higher following their experience of the learning model. A copy of all respondents' pre-intervention survey comments can be found in Table 3. A copy of all respondents' post-intervention survey comments can be found in Table 4.

Discussion/Conclusion

Pair-wise comparisons of pre to post-intervention survey results have demonstrated that early curriculum contextual learning in physical therapist education is valuable in improving student ratings of clinical self-preparedness and of fellow classmates' readiness to enter the clinic. Additionally, following the learning experience, students recognize the benefits provided by contextual learning. Subjects' ratings clearly demonstrate a belief among students that utilizing live hospital patients as models can provide beneficial learning opportunities. Students also describe themselves as more willing to spend extra time and expense to avail themselves of the learning opportunities.

A comparison of our results with any other previous work is not possible, as no other similar study that investigated student self-perceived readiness coupled with contextual learning experiences is available. Other studies have investigated strategies to decrease health care student anxiety through peer instruction¹⁶⁻¹⁸ and the use of humor;¹⁶ however, none have evaluated student perception of clinical preparedness. Lewis et al¹⁹ studied students in their second year of physical therapy education by utilizing simulated patients in the development of interpersonal skills,

and found this experience to be of benefit in decreasing anxiety and improving confidence. Although valuable, we propose that the present study is more readily generalizable to entry-level confidence in that the use of standardized patients does not provide the level of self-clinical confidence that contextual learning with real hospitalized patients can provide. This premise is supported by the findings of Panzarella and Manyon²⁰ in that second-year student physical therapists integrating standardized patient examination did not believe that the examination emulated an actual patient visit extremely well (21%), even though the expert observer rated the experience to emulate true patient care extremely well (73%). Our premise is also supported by post intervention comments (Table 4) such as, "The hospital visits definitely change the way I think," "I like that the patient can't "forget" his or her ailment like an actor can," and "Working with a real patie(n)t was exactly what I needed to reassure myself that I am retaining and able to apply my knowledge in real life situations."

Based on the results of our study, the integration of contextual learning for a first-year student physical therapist prior to any scheduled full-time clinical experience, shows promise for improving self-perceived level of clinical readiness. Real patients provide practice in interviewing skills, opportunity to experience normal and abnormal tone, range of motion, or strength, opportunity to experience limitations in functional mobility and cognitive function, and opportunity to practice culturally appropriate communication. The experiences provide practice with patients that are difficult to simulate authentically in the classroom with able-bodied classmates or faculty.

The benefits of contextual learning inclusion early in a DPT program are not without question. No studies have compared the actual clinical benefits of utilizing student companions or faculty as patient models with that of real patients, nor has the comparison been made with the standardized patient. Moreover,

providing students the opportunity to practice individually or in small groups with real patients requires supervision, which can be very time consuming and costly. State supervision statutes may require the licensed therapist to provide direct in-line-of-sight supervision, thus precluding the ability to observe multiple students as can be done in the classroom laboratory setting where students evaluate each other. However, with the assistance of willing clinicians and educational-program-associated faculty, the burden of supervision by academic faculty can be mitigated easily. Additionally, this method of involving additional clinical staff provides the benefit of students observing and being mentored in varying styles and techniques of patient management in the clinical setting.

Without question, these rich-learning environments provide a learning opportunity that is difficult, and often not possible, to accomplish in the classroom. Implementing such a model in all physical therapist and assistant education programs would be desirable. The inclusion of brief clinical experiences may help satisfy the hunger for learning experiences outside of the classroom that each first year student exhibits while incorporating tangible and educationally-productive examples into the classroom. Programs across the nation have incorporated short-term observation experiences into their professional curriculum; however, an observation cannot provide the same opportunity for learning as active participation does. The contextual learning model can afford the student an opportunity to bridge the gap between academic instruction and patient care, recognized as a major issue for academic staff in education.¹⁹ True contextual learning experiences take the learning opportunities even beyond the present practice of incorporating standardized or simulated patient encounters.

Adequately implementing this model of real-life clinical practice on a grander scale will require a cooperative learning environment among academic faculty, clinical faculty and clinicians. A team

approach toward the experiential learning model involving the classroom and field instruction is likely to involve many clinicians presently serving in a clinical instructor role, or those desiring to be involved in the clinical education process. With a team approach, contextual learning experiences early and often in the DPT curriculum may produce students with increased confidence in their own skill sets, who ultimately become more productive and effective physical therapists earlier in their careers. Further study investigating the clinical performance of students involved in contextual learning experiences is warranted and encouraged.

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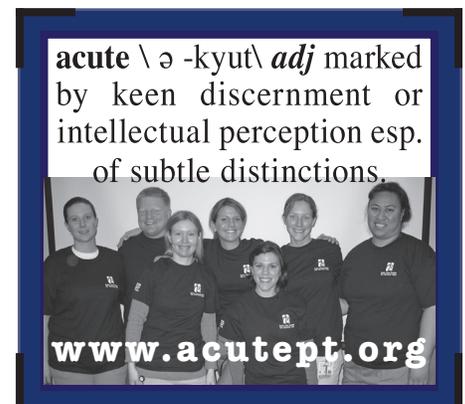
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Table 1- Survey Layout

<p>Please rate YOURSELF in the following categories for YOUR OWN sense of preparedness to perform a physical therapy assessment of an acute care hospital patient:</p>					
<p>1. I feel prepared to practice my skills on persons other than my classmates and instructors.</p>	<p>Not at all Prepared</p>	<p>0 1 2 3 4 5 6 7 8</p>	<p>9 10</p>	<p>Completely Prepared</p>	
<p>2. I feel prepared in my own readiness to see a "real" hospital patient.</p>	<p>Not at all Prepared</p>	<p>0 1 2 3 4 5 6 7 8</p>	<p>9 10</p>	<p>Completely Prepared</p>	
<p>Please rate YOUR CLASSMATES in how well prepared you believe THEY ARE to perform a physical therapy assessment of an acute care hospital patient:</p>					
<p>3. I feel MY CLASSMATES are prepared to practice their skills on persons other than classmates and instructors.</p>	<p>Not at all Prepared</p>	<p>0 1 2 3 4 5 6 7 8</p>	<p>9 10</p>	<p>Completely Prepared</p>	
<p>4. I feel MY CLASSMATES are prepared to see a "real" hospital patient.</p>	<p>Not at all Prepared</p>	<p>0 1 2 3 4 5 6 7 8</p>	<p>9 10</p>	<p>Completely Prepared</p>	
<p>Please indicate how valuable you believe real in-hospital assignments would be to your educational experience as a physical therapist by answering the questions below:</p>					
<p>5. I feel that using actual patients would be a valuable learning experience.</p>	<p>Completely Disagree</p>	<p>Somewhat Disagree</p>	<p>Neither Agree Nor Disagree</p>	<p>Somewhat Agree</p>	<p>Completely Agree</p>
<p>6. I feel that using real patients would allow me to learn things that are not otherwise possible.</p>	<p>Completely Disagree</p>	<p>Somewhat Disagree</p>	<p>Neither Agree Nor Disagree</p>	<p>Somewhat Agree</p>	<p>Completely Agree</p>
<p>7. I would be willing to spend extra time and/or effort to experience actual patient encounters early in my education.</p>	<p>Completely Disagree</p>	<p>Somewhat Disagree</p>	<p>Neither Agree Nor Disagree</p>	<p>Somewhat Agree</p>	<p>Completely Agree</p>
<p>8. I would be willing to incur extra expense, such as travel, to experience actual patient encounters early in my education.</p>	<p>Completely Disagree</p>	<p>Somewhat Disagree</p>	<p>Neither Agree Nor Disagree</p>	<p>Somewhat Agree</p>	<p>Completely Agree</p>
<p>Please add any other information that you feel would help describe your position on the usefulness or value of employing "real" patients early in the educational process of a physical therapist.</p> <p style="text-align: center;">(Open Text Response)</p>					

Table 2- Results of Survey Responses (n= 33)

Survey Question	Pre-Intervention Mean + Std Dev	Post-Intervention Mean + Std Dev	Change Pre->Post	Sig. (t-test)	
1. I feel prepared to practice my skills on persons other than my classmates and instructors.	5.39 (1.30)	7.27 (1.33)	+1.88	<.000	
2. I feel prepared in my own readiness to see a "real" hospital patient.	5.15 (1.50)	7.03 (1.55)	+1.88	<.000	
3. I feel MY CLASSMATES are prepared to practice their skills on persons other than classmates and instructors.	5.58 (1.32)	7.42 (1.28)	+1.85	<.000	
4. I feel MY CLASSMATES are prepared to see a "real" hospital patient.	5.42 (1.41)	7.21 (1.39)	+1.79	<.000	
	Pre-Post Sum Negative Ranks	Pre-Post Sum Positive Ranks	Pre-Post Ties	Z	Sig. (Wilcoxon)
5. I feel that using actual patients would be a valuable learning experience.	0	15.0	28	2.236	.025
6. I feel that using real patients would allow me to learn things that are not otherwise possible.	0	55.0	23	3.162	.002
7. I would be willing to spend extra time and/or effort to experience actual patient encounters early in my education.	0	210	13	4.472	<.000
8. I would be willing to incur extra expense, such as travel, to experience actual patient encounters early in my education.	0	210	13	4.179	<.000

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Pre-visit survey comments (unedited)

- | | | |
|--|--|--------------------------------|
|  Find | 1. We can only learn so much from text books and by practicing on other healthy students. With supervision, real patient interaction would be beneficial for a number of reasons. | Wed,
2/25/09
5:35
PM |
|  Find | 2. During the combined sections week I took a couple of days and went follow a Therapist that I worked with previously and honestly those two days of seeing patients gave me more of an education on patient therapist interaction than anything I have done so far it was a very valuable experience. | Wed,
2/25/09
1:41
PM |
|  Find | 3. The opportunity to evaluate, assess and formulate PT diagnoses on real patients is an invaluable tool for a student's education. | Wed,
2/25/09
11:22
AM |
|  Find | 4. I think tomorrow should be a great experience. I just hope that I can get over the nerves of being in a real life setting, especially in a hospital. | Wed,
2/25/09
11:13
AM |
|  Find | 5. Honestly, I don't feel totally prepared to go into the hospital and do gait training with assistive devices. I would say this is mostly my own fault because I didn't stay for the optional day with Dr. Gravano. And then the 2nd day we did it, it was just kind of a teach yourself day and not actually gone over in front of the class. If there were videos available to look at the gait a little more, that would help alot to study it a little more before going to teach actual patients. I do think that clinical experience is very important because that is the only way to learn but i do feel somewhat unprepared. | Wed,
2/25/09
10:06
AM |
|  Find | 6. The survey will not allow me to put the answers I would prefer for every question - won't allow me to put any answer twice in one question. I think using actual patients would be very helpful. I also think it could be helpful to observe instructors going through an exam with an actual patient. | Wed,
2/25/09
10:04
AM |
|  Find | 7. I feel that seeing real patients is a good opportunity to learn because I feel that you learn more by doing clinical experience instead of from a textbook. However, I do not feel confident enough in what i know to go into a clinical experience and perform evaluations, gait training, etc. without supervision and/or coaching. | Wed,
2/25/09
10:00
AM |
|  Find | 8. I feel that I am prepared to observe real patients, but as far as actually practicing on a real patient is discomforting. I am worried about their safety. | Wed,
2/25/09
9:48
AM |
|  Find | 9. I don't agree on already having to do an evaluation on a patient. I understand we should have some interaction with patients during our first year, but let use ease into it. The pressure that we will be under having to do a real evaluation on a patient on only our second encounter with a patient will probably be overwhelming for the majority of us. Most of us will be so nervous that we will not be able to perform to our potential. I think we should have much more experience with patients before we actually have to do an evaluation. | Wed,
2/25/09
9:45
AM |
|  Find | 10. I think this is very necessary. These interactions with 'real' patients will really help all of the info we've learned sink in instead of just having it floating around in our heads. | Wed,
2/25/09
9:31
AM |

Post visit survey (unedited)

- In our group, I liked how the pt evaluation never really resulted in what was expected. We had the chance to use other skills that we don't hardly ever use with the ICALs. The hospital visits definitely change the way I think. Mon, 3/30/09 12:43 PM
- I like that the patient can't "forget" his or her ailment like an actor can Mon, 3/30/09 12:02 PM
- It would be very beneficial to have more hospital visits for practice if possible. Not all the visits should be graded, but rather used as a learning experience to take the pressure off the experience. Mon, 3/30/09 8:43 AM
- Gaining "on the job" or actual experience is a necessity for mastering any skill, and physical therapy is no exception. I believe that practicing with real patients is one of the most important things we do here. All the information in the world will be useless unless we can successfully interact with patients. I think that the experience we are getting from the hospital/lab/ICALs will prepare us for our upcoming clinicals. This experience will allow us to spend less time getting acclimated to seeing real patients, which will allow us to get more out of our clinicals. Limited resources are the reason for less than 100% agreement to take on some extra expenses. Mon, 3/30/09 4:41 AM
- I feel that I learned more in that 30 minutes with the patient than I did in days of classtime. I believe that doing is the only way to learn things. I believe that ICALS are valuable as far as getting one on one feedback with faculty while performing our skills, but the amount of preparation it takes leading up to ICAL could be used more wisely on other things. The stimulus questions for ICAL sometimes take up to 10 hours out of my week that I could be used studying for more important things. But yes, the hospital visit was worth every minute i spent there. That is what is going to make us better therapists. Fri, 3/27/09 10:14 PM
- I believe practicing on real patients is an excellent way to see all aspects of care. We are forced to adapt to real life situations and personalities. Fri, 3/27/09 4:28 PM
- Great experience! Seeing a real patient helps develop that thought process that cannot be simulated in mock evals. Fri, 3/27/09 3:58 PM
- this last hostpital visit was a woderful expereice. Working with a real patiet was exactly what I needed to reassure myself that I am retaining and able to apply my knowledge in real situations. I'm looking forward to my first internship this summer so that I can have these interactions on a daily basis. Fri, 3/27/09 1:53 PM
- I think the patient eval. went well yesterday. I definitely learned that a patient can be too talkative. We had a lot of trouble keeping him focused on the interview so we could finish it up. It showed me what I need to work on. Fri, 3/27/09 1:44 PM