Clinical expertise: Learning together through observed practice

The popularity of inservice training programmes and short courses, as well as clinically related MSc courses in higher education, suggest that manual therapy practitioners are only too aware of a need to enhance clinical effectiveness and efficiency. While national professional bodies may consider continuous professional development (CPD) activity as obligatory, practitioners themselves have long been driven by a strong moral responsibility to improve what they do for their patients, investing both their time and finances in their learning.

But what sort of learning do they do and is it effective to develop clinical expertise? Typically, CPD activities involve in-service training in the workplace and short courses away from the workplace that focus on relevant literature and research and hands-on skill. Practitioners perform techniques on each other with guidance from someone with expertise. Practitioners then go back into clinical practice and apply their new knowledge and skill to patients. Over time, practitioners see numbers of patients and gain experience and ‘patient mileage’ (Richardson, 1996, 1999). Will this CPD diet of patient experience, in-service training and short courses, result in enhanced clinical practice; will it lead to clinical expertise?

To address this question, the literature related to professional development (CPD) activity as obligatory, practitioners themselves consider the benefit of this at different stages of practitioner’s clinical development. It is acknowledged that observation and feedback are an important part of the growth and development of newly qualified practitioners (McInstry, 2005; Tolal-Sullivan, 2006; Morley, 2007). For example, Morley (2007) found that observed practice by a more senior practitioner, as part of a formal perceptorship programme, increased confidence and clinical competence. In turn, the observer valued the process as a way of accessing the new practitioners’ thinking, particularly in situations where there was little or no co-working. While observed practice is rarely considered as a learning strategy for more experienced practitioners, there is recent evidence of its worth in UK physiotherapists undertaking a musculoskeletal practice-based MSc (Pett, 2009). Observed practice by a more experienced practitioner was identified as the most powerful learning process to foster their development towards clinical expertise. Why is observation of practice considered so helpful? To address this, the benefits of being observed by a colleague as well as observing a colleague with greater expertise needs to be explored?

1. Being observed by a colleague

An observer watching a colleague manage a new or follow up patient appointment is able to stand back from the situation and see the interaction as a whole. While it is an encounter with just one patient, it provides a specific example of the practitioner’s practice and may offer a rich learning experience. The nature of that experience will, in part, be determined by the relative...
experience of the observed and observer. The value of a practitioner with higher levels of expertise enhancing the practice of someone less experienced through observation is well supported by the literature (Fish and Twinn, 1997; Daloz, 1999; Titchen, 2001). Within physiotherapy, clinical ‘experts’ have consistently recalled the powerful impact of learning in practice with patients in the presence of an expert guide and teacher (Jensen et al., 1999) and remains a requirement for all manual therapy courses that have membership of the International Federation of Manipulative Therapists (IFOMT). However, being observed by a peer with similar levels of knowledge may also be valuable as they share their practice and learn from each other.

The practice knowledge, (defined here as all types of knowledge and skill) of the practitioner is, in part, revealed to the observer through the actions and decisions they make with the patient, as well as the debrief afterwards. ‘What did they think about the patient’s recent weight loss?’ ‘Why did they choose the straight leg raise and not the slump?’ ‘How will they progress treatment?’ Like an iceberg, a great deal of practice knowledge tends to remain hidden (Argyris and Schon, 1974; Fish and Coles, 1998). The observer, through questioning, can raise the practitioner’s awareness of this hidden, and perhaps taken for granted knowledge, discuss and share, and thereby enhance it. Another advantage of direct observation is that much of practice knowledge is tacit or difficult to articulate (Eraut, 1994; Fish, 1998; Titchen and Ersser, 2001). Skill in analysing posture or palpation for example, are very difficult to describe in words. These aspects of practice can be readily shared as each practitioner observes or palpates the patient and discusses their findings. Bringing to light all forms of practice knowledge provides the potential for affirmation and enhanced confidence, as well as change and improvement.

2. Observing a colleague

The opportunity to observe a colleague with a patient may also provide a valuable learning opportunity. Observational learning is highlighted in the literature and considered a potentially powerful process (Bandura, 1997; Titchen, 2001). The observer may gain confidence seeing similar actions to their own, as well as seeing alternative ways to do things that they then may adopt into their own practice. The degree to which this happens will, in part, depend on the relative experience of the observed and observer. Someone with clinical expertise may become an inspirational role model for a novice practitioner. In this situation, observation may raise awareness of a much higher level of practice and professional behaviour, triggering their need to learn, and inspiring their subsequent professional development. Where the observer is more experienced, the process may offer alternative ways to practice as well as affirm and consolidate their practice knowledge. Where the observed and observer are peers with similar experience and knowledge, observation may provide each other with significant help and support as they grapple with similar issues.

Introducing observation of clinical practice in the workplace may be strongly resisted by practitioners. They may feel too vulnerable and fear harsh and negative judgment of their clinical practice. They may feel anxious that if this happens they will lose respect and have promotion blocked. However, while independent practice may protect them from criticism, it prevents them receiving encouragement, support and guidance. It may also limit their potential to develop high levels of clinical expertise. For observation of practice to be successfully implemented in the workplace, it is imperative that everyone involved acknowledges and sensitively manages the power relationship between the observed and the observer. Fundamental to this, is a collaborative, respectful, supportive environment that genuinely desires to facilitate learning and expertise in each other. Everyone from consultant to newly qualified practitioner needs to continually learn and develop their practice. All aspects of knowledge applied in clinical practice needs to be addressed, not just technical skill. We would argue that direct observation of practice offers a powerful, yet readily available tool in the workplace, to enhance clinical practice and maximise patient outcomes for both individual practitioners and clinical teams.

References

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