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"1000 hours: to be or not to be"

Evidence for 1000 hours of fieldwork in occupational therapy

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There are challenges, which have been developing for some years in regards to the availability of places for allied health clinical student placements. Indeed, according to many authors, the current economic climate means that fieldwork education has reached a crisis point with a critical shortage of placements reported worldwide (Adamson, 2005; Craik and Turner-Healey 2005; James and Prigg 2004; Waters, 2001). Some of the issues faced in student clinical placements include difficulties in finding placements; finding clinicians to supervise; excessive workload of clinicians; lack of resources for hosting students; and, inconsistency in skills of clinicians who act as supervisors (Rosenwax et el 2010). For occupational therapy, the current regulations require that students complete a minimum of 1000 clinical hours over the course of their degree (Coyle 2007; Holmes 2010; Levett-Jones 2008). Table 1 presents the number of hours required across several allied health, medicine and nursing professions.

This discussion paper investigates the evidence supporting the number of hours required for student clinical placements. Table one is a comparative table and includes medical and allied health professions and the length of their undergraduate course and the minimum number of clinical hours that are required of students to complete their degree.

The World Federation of Occupational Therapists (WFOT) website states the set minimum of 1000 hours required for occupational therapist students (WFOT, 2011) as well as suggesting that placements should be of varying length in different sites. When reviewing papers on clinical placement we looked beyond occupational therapy to other allied health professions and what they were experiencing. There is, according to Levett-Jones (2008:14) little contemporary evidence behind minimum number of hours for nursing clinical placements, rather they have simply evolved over time. Nor is there, according to McAllistar (2005:145) much evidence currently to support the minimum number of clinical hours (350) required by Speech pathologists. Edmond (2001) has argued that it is not the number of clinical hours that is important but the quality of the time spent in clinical placement. Levett-Jones (2008) seems inclined to support fewer student clinical placements but of longer duration. However, in research conducted amongst social workers in the UK (Moriarty et al 2010: 588), placement supervisors felt that although extended placement hours may be beneficial, they felt that it placed extra pressure on staff and the agency. Obviously changes to the structure of placements would need to be agreed to by key stakeholders.

Effects of nursing clinical hours on student outcomes were examined in two pilot studies. Russell and Pepa (1998) examined how reduced clinical hours affected students' critical thinking abilities. The Clinical Nursing Assessment Medical–Surgical Nursing I (National

League for Nursing, 1993) was used to measure matched groups of the junior bachelor of science in nursing (BSN) students (n =7) who had completed a medical–surgical clinical rotation and junior BSN students (n =7) and who experienced reduced clinical hours. No significant differences in nurses' clinical thinking skills were found between the two student groups, despite a reduction in clinical time. The results of this study is supported by Coyle (2007) who has argued that there seems little empirical evidence for the current number of minimum clinical hours required.

It is important to look at innovative ways of approaching the delivery of clinical experience to students, not least because of the difficulty in finding suitable clinical placements. This difficulty is widespread across the majority of allied health degrees. One strategy to reduce the number of clinical hours was carried out in the Russell & Pepa (1998) study. In this study fieldwork hours were replaced with teaching clinical case studies, interactive videos and computer-assisted instruction. Although Cox (1997) suggests that nothing can replace the complexities and situated knowledge in the real world, there is little research on the number of hours required in the real world.

Only one paper was found that had conducted research on the value of the 1000 hour minimum clinical placement requirement for OT students (Holmes et al., 2010). The 400 students in this Canadian study were a mix of Bachelor degree students and masters entry students across six occupational therapy programs. The authors concluded that the minimum of 1000 hours was appropriate, although practice knowledge, clinical reasoning, and facilitating change just fell short of entry level competence after 1000 hours. There were a number of limitations to the study. First, a comparison could not be made with students who had not completed the required minimum number of hours. (Such a comparison was nigh impossible to achieve when 1000 hours is mandatory.) Second, Holmes et al. examined the archival data of the scores of students both mid-way and at the end of their placements using the Competency Based Fieldwork Evaluation for Occupational Therapists (CBFE-OT) method of assessment (Bossers et al., 2002, 2007). (This instrument is designed to evaluate occupational therapy students' performance during their fieldwork placements on seven practice competencies.) Holmes et al. acknowledged that students at stage 1 typically scored between 1 and 3, and at stage 2 they scored between 3 and 6 and at stage 3 students scored between 6 and 8. This trend in scores by fieldwork supervisors may indicate a predisposition for fieldwork supervisors to score according to the marking guidelines. Further investigation into the evidence supporting the minimum hour requirements needs to be conducted.

Having a minimum number of clinical hours to achieve competency, implies that all students learn in the same way and at the same pace. One would assume, like most other learning outcomes, this would not be true. It would be safe to assume that some students would

become competent much sooner than others and some may never reach competency despite having completed the hour requirements. As Hale, (2003:18) states, 'there is no evidence of how many clinical hours are needed to produce a competent capable nurse'. Furthermore, Coyle (2007) concluded that in New Zealand there was poor concordance as to what constituted a 'clinical hour'. Indeed in the mid-1980s the promotion of clinical skills by repetition of task was the dominant idea but this methodology has been challenged recently (Amato 2002; Higgs, Burn, Jones 2001) by proficiency-based mastery based on empirical evidence. Thus, there are tensions between practicing clinicians who suggest that allied health are essentially practical, and educators who contend that it is based on expanding ideologies and knowledge through research-based knowledge. Clinical fieldwork is essential in developing a competent practitioner (Kirke et el 2007) but the structure and degree of this is unclear.

From Coyle's research there were some key themes about the nature of clinical fieldwork. Among them were that regulators were unclear: why the minimum number (1000 hours) of clinical time exists; what a clinical hour actually was; and that there are serious problems in meeting the required number of clinical hours (Coyle 2007: 72). According to Rosenwax et al, as of 2009 when their paper was published there had been minimal evidence presented regarding evidence for the structure of effective clinical education programs, taking into consideration the need to obtain successful outcomes for students, host sites, supervisors, universities and consumers (Rosenwax et al 2009:11). Rosenwax et al conducted a pilot of a clinical placement program, the Gribble Rosenwax Advanced Clinical Education (GRACE) program. In the GRACE program, student placements are conducted 42 consecutive weeks of the year, rather than intermittently (Rosenwax et al 2009:11). In its second year, all students (n=490) gained placement allocations earlier than previous years. Blocks are of 7-week duration. Within the GRACE program, contractual agreements were negotiated with host sites. Rosenwax et al (2009) provide several benefits of their program which are outlines in their paper. Another model, called the 2:1 model or a collaborative framework, is based on the idea that one educator works with two students (Fisher & Savin-Baden 2002: 278) acting as a resource for the students who take on the responsibility of casework.

In contrast to minimum hours, midwifery assesses the competency of trainee midwives by number of birth experiences. To qualify midwives must have 40 birth experiences (Pincombe et al 2007). The Pincombe et al paper reports a study, which aimed to gain consensus from experts regarding the appropriateness of using minimum requirements of birth and follow-through experiences for registration purposes in Australia. The findings from the original study (this paper reports on stage two of the research), found that there was consensus that there should be prescriptive criteria to measure competence. There were a number of significant issues in regards to achieving minimum requirements in practice, re-iterating that this is a common problem across many allied health and medical

disciplines. Again they found that evidence did not exist to support the set requirements for minimum competency (Pincombe et el 2007: 377-378).

Table 1

Comparison of course duration and minimum clinical hours required for medicine and allied health student competency

Course	Undergraduate Course length (years)	Clinical hours minimum
Occupational therapy	4	1000 hours (International standards)
Speech pathology	4	350 hours
Physiotherapy	4	850 hours (1000 in NZ)
Podiatry	4	1000 hours (Aus & NZ)
Dietetics	4	760 hours
Play therapy	15 days (diploma)	450 hours (accredited)
Dentists	5	no minimum
Optometry	5	1 year
Pharmacy	4	no minimum
Medicine	5-6	1800-2600 +1 year post degree
Nursing	3	800 hours
Social work	3	980 hours
Psychotherapy	7	300-600 hours of clinical practice with clients/patients either within a mental or social health setting, or equivalent; either with individual clients/patients, families or groups, under regular supervision 150 hours of supervision of an effective clinical practice Note: placement doesn't usually occur in the 1st 2 years of training.

Note for pharmacy : As there is no evidence-based information with regards to the number of hours required for students to obtain appropriate clinical skills during undergraduate education programs, the APC does not prescribe a benchmark figure for clinical placement hours (page 8 The APC Accreditation Standards Version 1.0 July 2009 replaces the NAPSAC Accreditation)

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