Capacity Building for Clinical Supervision in Allied Health in Vietnam

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Since Vietnam's first speech therapists (ST) graduated in September 2012 they have been involved in a capacity building program to become skilled clinical supervisors (CS) by (1) acting as co-supervisors of current ST students with visiting Australian supervisors and receiving on-the-job role mentoring from them; (2) participating in a Supervisor Development Program (SDP). The SDP consisted of six 3 hour sessions covering planning for placements, teaching and feedback techniques, peer learning, reflection, evaluation of placement outcomes, development of self-as-clinical supervisor. Translation of program notes and in-class interpreting between English and Vietnamese was provided by experienced translators/interpreters. The program was highly interactive and the presenters role-modelled techniques throughout. With the participants' Informed Consent, their reactions to the content and techniques, and suggestions for modification were digitally recorded during the sessions, and in dedicated focus group times. Transcripts were analysed to identify participants' perceptions of content and techniques that are and are not culturally and pedagogically appropriate for teaching allied health students in Vietnam. Their suggestions for modification of the program will be incorporated in a revised program and delivered with their involvement for future allied health graduates. Lessons from this two-stage approach to supervisor development are applicable to the Australian context.

Keywords: Capacity building, clinical supervision, allied health, speech therapy, indigenisation

INTRODUCTION

Western models of education and training (WMET) in health and social care services have been imposed on or adopted by many developing countries (such as in Africa and Asia) in the past without always showing consideration for local contextual factors such as culture, values and belief systems. Several authors have questioned the transferability of WMET to developing countries because of the failure of such models to accommodate local factors such as poverty, local religious practices and beliefs and the ways in which people learn and work (Lan *et al.*, 2010). Further, consideration needs to be given to differences in communication style, ways of giving and receiving positive or negative feedback and power differences between staff and students. Kreitzer *et al.* (2009) examined past influences of colonialism, modernisation and globalisation and described the impact those factors had on the social work education and curriculum development in Ghana. Indigenisation is a term used in social work education to describe the process of adaptation of the Western values, knowledge and skills to a non-Western context using an appropriate cultural lens. Yan (2013) argues that different components of social work (knowledge, skills and values) can be separately imported and adapted using the indigenisation process so that the models of social care are relevant for the local contexts. There is a need for the customisation of the WMET for health professions and supervisor training to enable culturally-appropriate education and training approaches appropriate for non-western countries. This paper describes an action research approach where Vietnamese CS act as co-researchers and agents of change with Australian CS/researchers to participate in a SDP, reflect on learnings and activities, and gather feedback on their experiences of the program. Findings will inform adaptation of an Australian SDP to the needs and contexts of allied health professionals in Vietnam.

METHODS

Participants were 10 graduates who completed Vietnam's first ST program in September 2012, a 2 year post-graduate program at Pham Ngoc Thach University (PNTU) in Ho Chi Minh City (McAllister *et al.*, 2013). Graduates were already practising in government hospitals as doctors, nurses and physiotherapists when they undertook the ST course. On graduation they returned to their hospitals to establish and deliver ST services. They have been involved since 2013 as co-supervisors of the current

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ST students at PNTU, being mentored by visiting Australian speech pathology CSs. Presenters of the SDP (authors 1 and 2) are experienced CS in Australia and in Vietnam, and have extensive experience as academics developing, delivering and evaluating SDPs to CS in Australia. They were well known to the course participants having lectured and supervised them on placement several times during their PNTU ST course.

The SDP is a two stage program: Stage 1 was delivered to the group over 6 three-hour sessions in January 2014. At the conclusion of the program, each participant set personal and peer group learning goals for follow up reflection and discussion in Stage 2, to be run later in 2014. In Stage 1, each session consisted of a mix of presentation of basic knowledge and skills overview, skills demonstration and practice, reflection and discussion, and group feedback on the cultural appropriateness and relevance of the content, skills and strategies, and challenges to implementation.

The program covered planning for placements, teaching and feedback techniques, peer learning, reflection, evaluation of placement outcomes and development of self-as-clinical supervisor. Program notes for each session were prepared in English by the presenters and translated into Vietnamese by a translator experienced in translation of course materials for the ST course and hence familiar with terminology. Students received these notes in advance of each session. Content in the sessions was delivered by the presenters in English with sequential interpretation from an interpreter who works for the ST course. A digital recorder ran for much of the teaching sessions and all of the research focus groups and notes were kept by both presenters. Where participants were talking simultaneously or over each other, as in discussions among students during skills practice sessions and role-plays in small groups, key content was summarised into English by the interpreter. Whole of class discussions, question/answer sessions between the participants and presenters, as well as the research focus groups were sequentially interpreted and then summarised by the interpreter for the digital audio-recorder.

Two data collection methods were planned: focus groups in each of the six SDP sessions, and the taking of summary notes of points raised during teaching sessions by participants. Summary points were made by a session facilitator on the whiteboard to guide students, and the other presenter not facilitating the session kept handwritten field notes as a backup in case of recorder problems as well as photographing the whiteboard summary.

The presenters/researchers listened to all digital recordings made during focus groups and in-class discussions and decided which were clear enough[1] for full transcription by experienced English-Vietnamese translators. Additionally, relevant, audible dialog was transcribed verbatim by the researchers. Photographs of all whiteboard summaries and field notes were analysed and triangulated with digital recording transcripts/notes to ensure key points and data categories were noted.

RESULTS

Several recurring key points were identified in the data and then clustered into content categories, consistent with approaches outlined by Weber (1990). Due to word length constraints, this paper presents two key categories:
    (1)   East/West differences;
    (2)   Being novice CSs in a new profession
 and the interaction between these two themes.

A more comprehensive description of the findings will be presented in subsequent publications.

East / West (Or Vietnamese / Australian) Differences

Participants were asked to discuss the differences they perceived between Western and Vietnamese CS in the context of ST clinical placements and additional comments were noted during sessions.

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[1] A noisy classroom environment and exuberant learners speaking simultaneously made full transcription of all recordings impossible.

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A number of comments related to trust, with Australian supervisors being seen as trusted to have knowledge, skill and the capacity to motivate. One participant said:

> … students trust the Australian CSs; students know they are instructors and accept that the CS may not know all the answers. Whereas in Vietnam, students expect their CS to know everything; this puts pressure on the CSs; if a Vietnamese CS doesn't know an answer, Vietnamese students lose trust … Students know the Vietnamese CS is a new speech therapist.

In this context questioning by the Australian CS was seen as a way to facilitate the student's learning "and make the student more independent"; whereas participants felt that if a Vietnamese supervisor asked a question it could be interpreted as the supervisor "not wanting to answer" or not knowing the answer, and therefore not gaining, or indeed losing, trust of the student.

How to give feedback and what to give feedback on was a frequent topic of discussion in the focus groups. It was stated that without correction the student will not change ("feedback must be accurate so the student can fix it") and correction needed to be made in a way "not to cause offence". Participants acknowledged that working with 'lazy' students was difficult but felt "no one will say that directly" to the student. "If that's the case, they will talk to him" but not be direct. Comment was also made that "the temperament of the student" may dictate whether feedback was direct or indirect. Much discussion took place relating to the possible emotional response of the student to CS feedback. The desire "to not offend" was mentioned, and concern was expressed that people receiving "negative feedback could become aggressive". It was also noted that if feedback is too straightforward it can lead to defensiveness and "feeling that the teacher hates them".

Being Novice CSs In A New Profession

Some participants described themselves as experienced CSs in their original profession. They commented that they were comfortable to provide modelling and feedback in that field, particularly regarding skills. One participant, an experienced physiotherapist before training to be a ST, went on to say that in his experience it was different in physiotherapy, "because the CSs are established clinicians and know more".

Participants felt that as ST CSs, they lacked the experience to provide modelling, feedback and teaching to student STs. In the context of physiotherapy supervision, one participant commented that the CS is responsible to "do training tasks well to increase the skill, knowledge and interest of students". As new STs, this was seen as difficult to achieve effectively. Another participant commented that "supervisors should model" but because the Vietnamese CSs are recently graduated, students don't expect so much of them. One participant said "it's really difficult because the CSs are learning themselves still".

There appeared to be some acceptance that skills or performance were easier, and perhaps more appropriate to comment on and modify, whereas commenting on knowledge base was less commonly addressed. "Students are very concerned about evidence-based practice (EBP) [a foundation of the ST curriculum] and so CSs need to make sure they are referring to current evidence". Participants repeatedly commented that the evidence-base in ST is limited globally, but especially in Vietnam. The profession is in its infancy in Vietnam and "there is no evidence in Vietnam yet". The literature is not available so "we cannot tell people to look it up".

DISCUSSION

Fear of having their precarious/limited knowledge base exposed is a common concern for novice CSs. New graduates in Australia when interviewed as novice CSs have also articulated their "fear of students' knowledge" (McAllister *et al.,* 2008). Most of the participants in this SDP had been mentored into their CS roles by visiting Australian CSs, working alongside them to supervise Vietnamese ST students and learn from role modelling and participation in the discussions with the students. Clearly this support needs to continue, to build both clinical knowledge and supervisory knowledge and skill.

Based on our previous teaching and supervision experiences in Vietnam, we had expected the issue of 'saving face' to arise in the discussions with the participants. It did so but indirectly, related to the issues of trust, not wanting to give direct negative feedback to students, but more importantly not wanting to have their own lack of knowledge and evidence-base exposed through interactions with students.

Gaining and keeping students' trust was of great concern. It seemed that the concept of 'trust' was seen as central to the effectiveness of CSs. This is an issue which merits further attention in subsequent studies and it will be important the interpretation of 'trust' into English is fully understood. This shared understanding would assist students as well as CSs both from Vietnam and Australia. In particular, for the CSs from Australia, it would be useful to make us more aware of risks around being seen as the source of knowledge and therefore not able to be replaced by locals.

It appeared that the issue of the newness of the profession in Vietnam closely interacted with the comments regarding the lack of EBP regarding ST in Vietnam. Participants expressed a need for experience as well as needing a relevant knowledge base for the Vietnamese setting. Clearly the development of indigenised, culturally relevant and scientifically valid approaches are necessary to empower the Vietnamese STs to be the instructors of future Vietnamese STs. At the same time, development of confidence in CS processes should enhance the indigenisation of the ongoing development of allied health in Vietnam.

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