Knowledge, Competence? and Expertise:
Making sense of challenges and creative moments in everyday practice

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Scientist, Centre for Ambulatory Care Education
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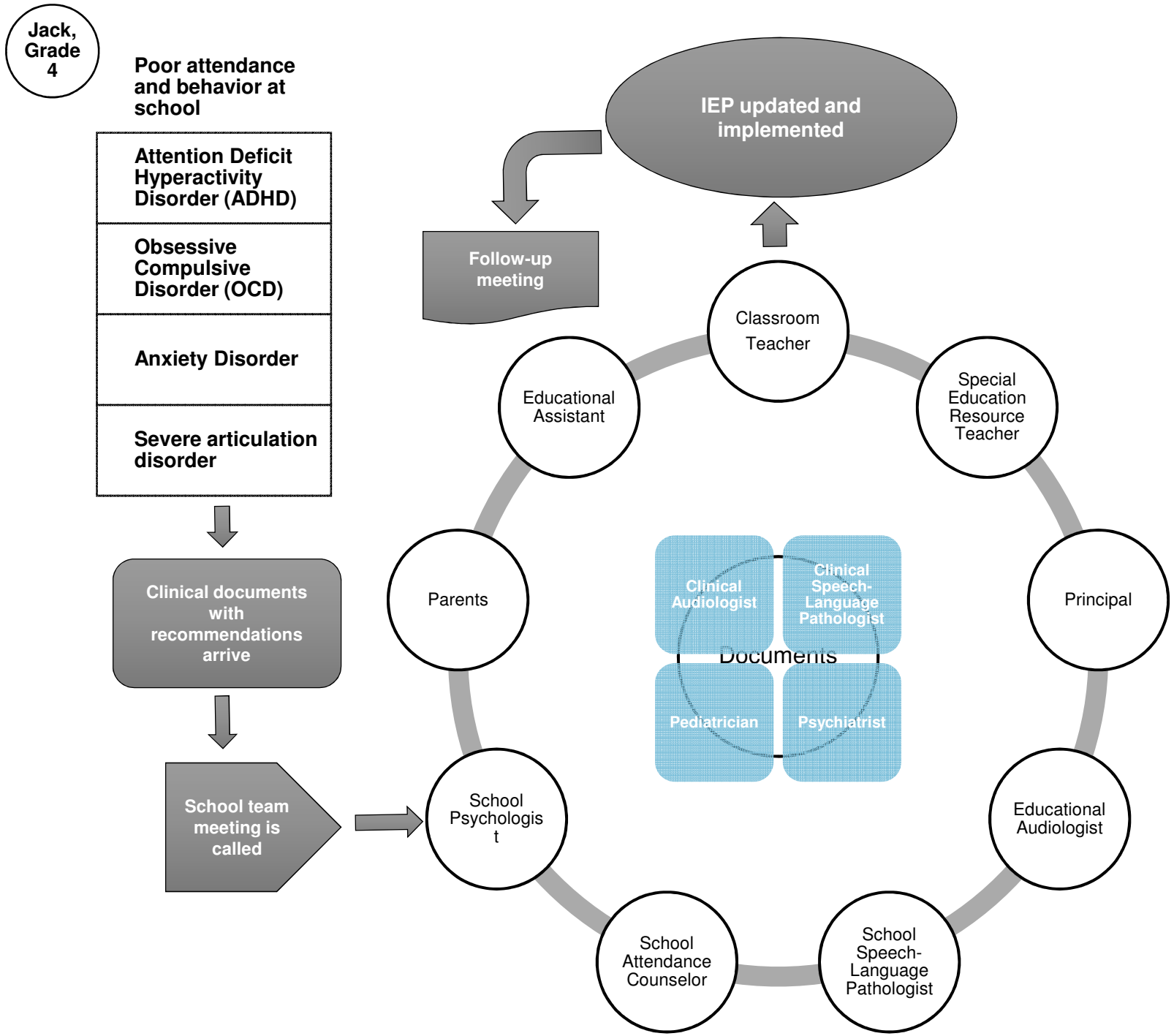

Jack, Grade 4
Poor attendance and behavior at school
Attention Deficit Hyperactivity Disorder (ADHD)
Obsessive Compulsive Disorder (OCD)
Anxiety Disorder
Severe articulation disorder
Clinical documents with recommendations arrive
School team meeting is called
IEP updated and implemented
Follow-up meeting
Classroom Teacher
Special Education Resource Teacher
Principal
Educational Audiologist
School Speech-Language Pathologist
School Attendance Counselor
School Psychologis t
Parents
Educational Assistant
Clinical Audiologist
Clinical Speech-Language Pathologist
Pediatrician
Psychiatrist
Documents

The Problems

(what really happened for Jack)

Frustration for Jack's family

Conflict between professionals

Delays and minimal support for Jack

The audiology-industry interface: could we do more to support student development?

I did not attend 7 years of university to be a sales person [...]! That might make me not cut out to be a clinician in private practice but my supervisor said the same thing, that she was not a sales person and she would never force a person to buy hearing aids. I think most clinicians feel this way; however, management tends to only focus on sales. It is not what I had anticipated at all, even when I was being interviewed [for my job], "patient care" [was] stressed upon me; however, I felt patient care [was] the last thing on their mind. Maybe I was very naïve to the sales aspect of audiology but like I said it [was] not even a factor in the 3 years of schooling.

From Ng et al 2012 – student participant

Social scientists study the social world.

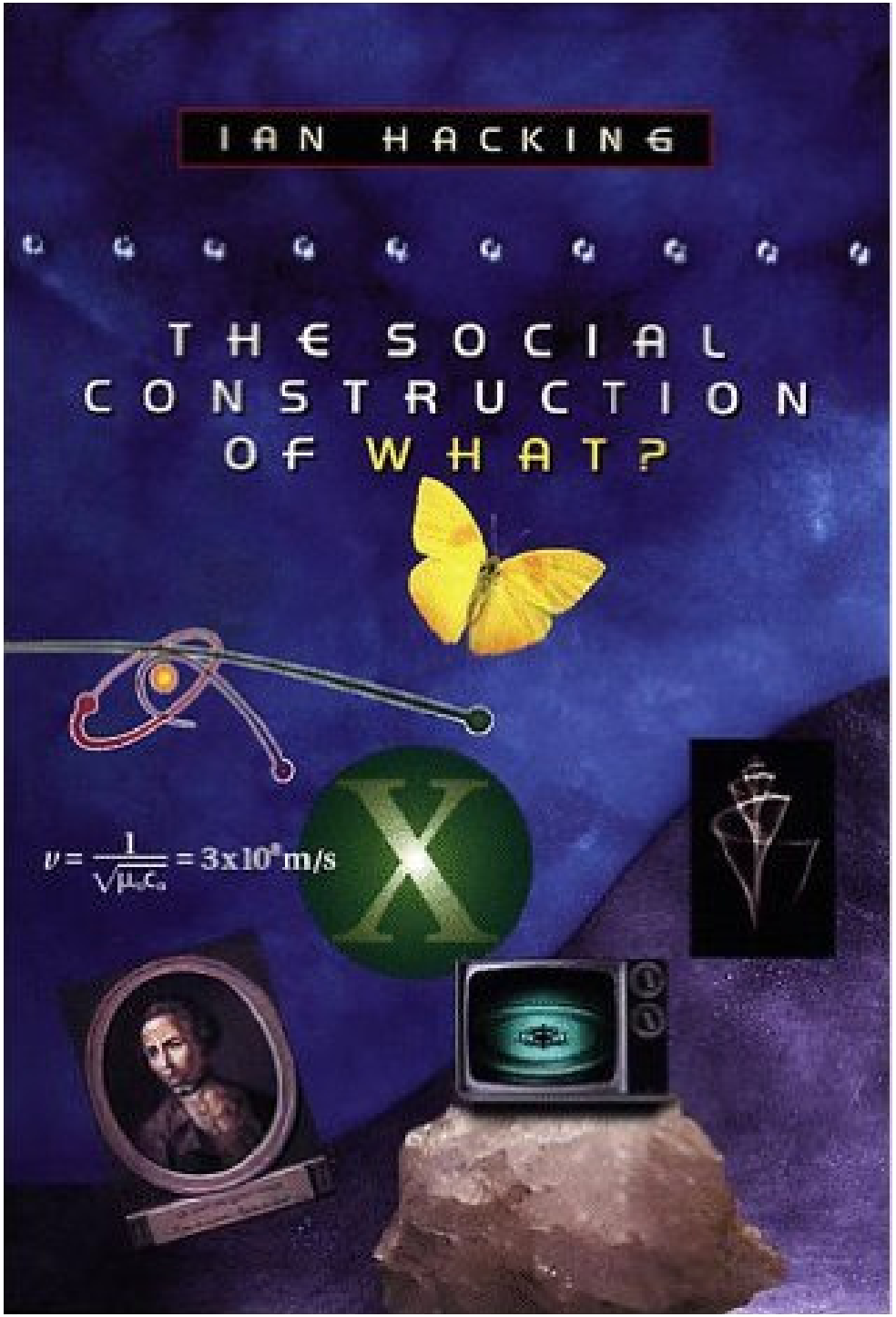
First, a pop quiz.

Which of these things is socially ***constructed***?

A. Gender (gendered roles & preferences)
B. Race
C. Professionalism
D. Competence
E. All of the above?

social construct, ***noun***

1. A social mechanism, phenomenon, or category, created by society.
2. A perception of an individual, group, or idea developed through cultural or societal practice.

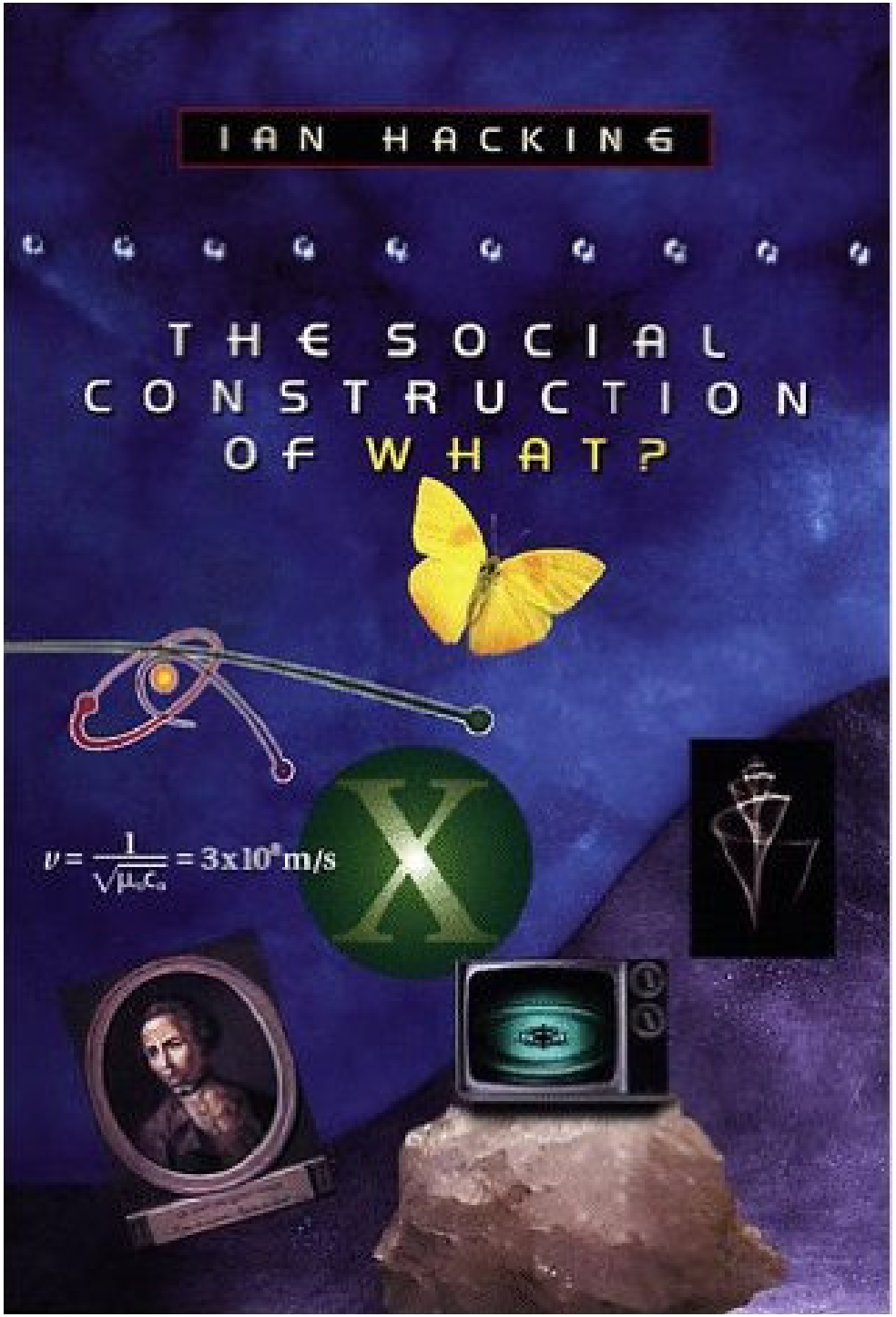


X is taken for granted; it appears inevitable

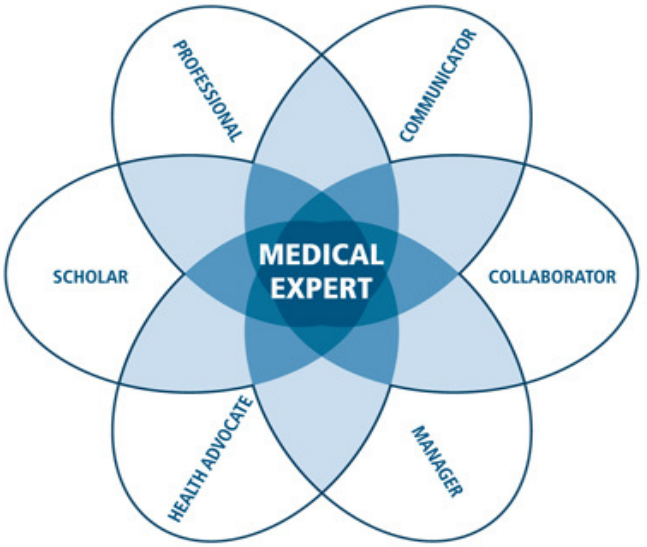
X need *not* have existed; it is not “natural;” it is not *inevitable*

X is problematic

We could be better off without X or with a change to X



Let x =



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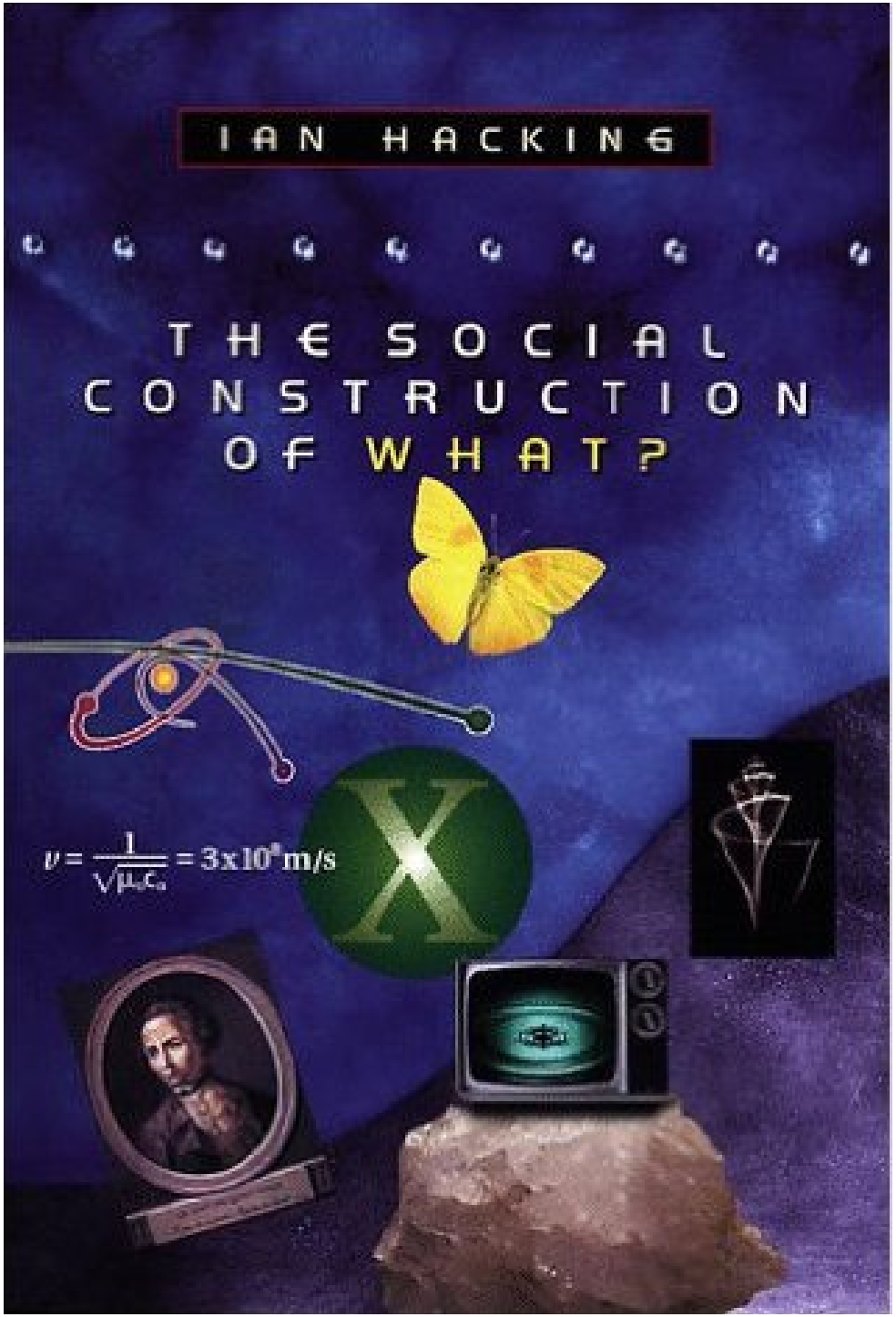


Competency-based education (CBE) is taken for granted; it appears inevitable

CBE need *not* have existed; it is not "natural;" it is not *inevitable*

CBE is problematic

We would be better off without CBE or with a change to CBE

We can **'deconstruct' our current social constructions** in order to see another way.

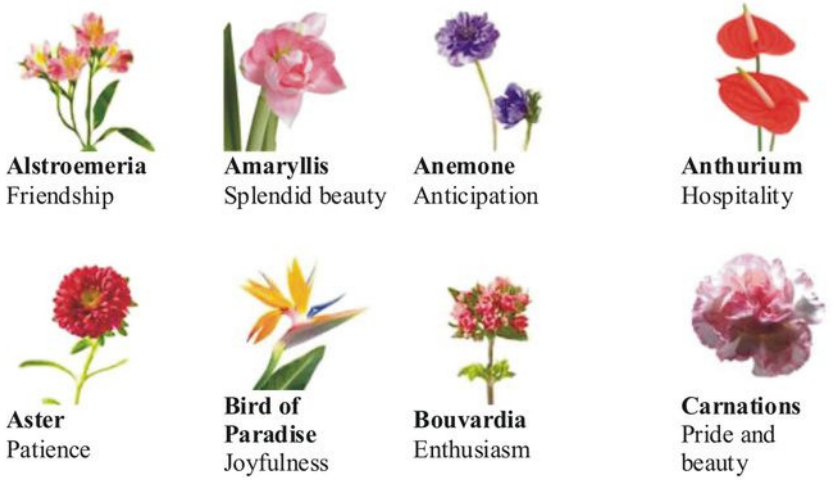
https://www.youtube.com/watch?v=vI-hifp4u40

In other words...


MENU
INFO.
AF-ON
SET
Canon
ON
OFF

Qualitative research

Constructs
understanding
of the social world.



And **deconstructs**
how we came to ‘see’ the
social world as we
currently do.

By the end of this session, participants will be able to:

1. Define and **deconstruct** knowledge, competence, and expertise in relation to clinical practice
2. Describe two concepts and two research studies that explain how individuals' practices are shaped and constrained (**structure and agency**)
3. Articulate a new way of seeing one's capacity to act in the face of systemic constraints and a unique paradigm for research in audiology (**critical reflexivity**)

3 bold statements, demonstrated through 2 research studies

1. Our current conceptions of 'knowledge' can obscure knowledge creation in everyday practice and silence patients/families

2. Our current conceptions of 'competence' fail to acknowledge and appreciate the complexity of everyday practice

3. Expertise – framed as critical reflexivity – can and should be a goal in the health professions

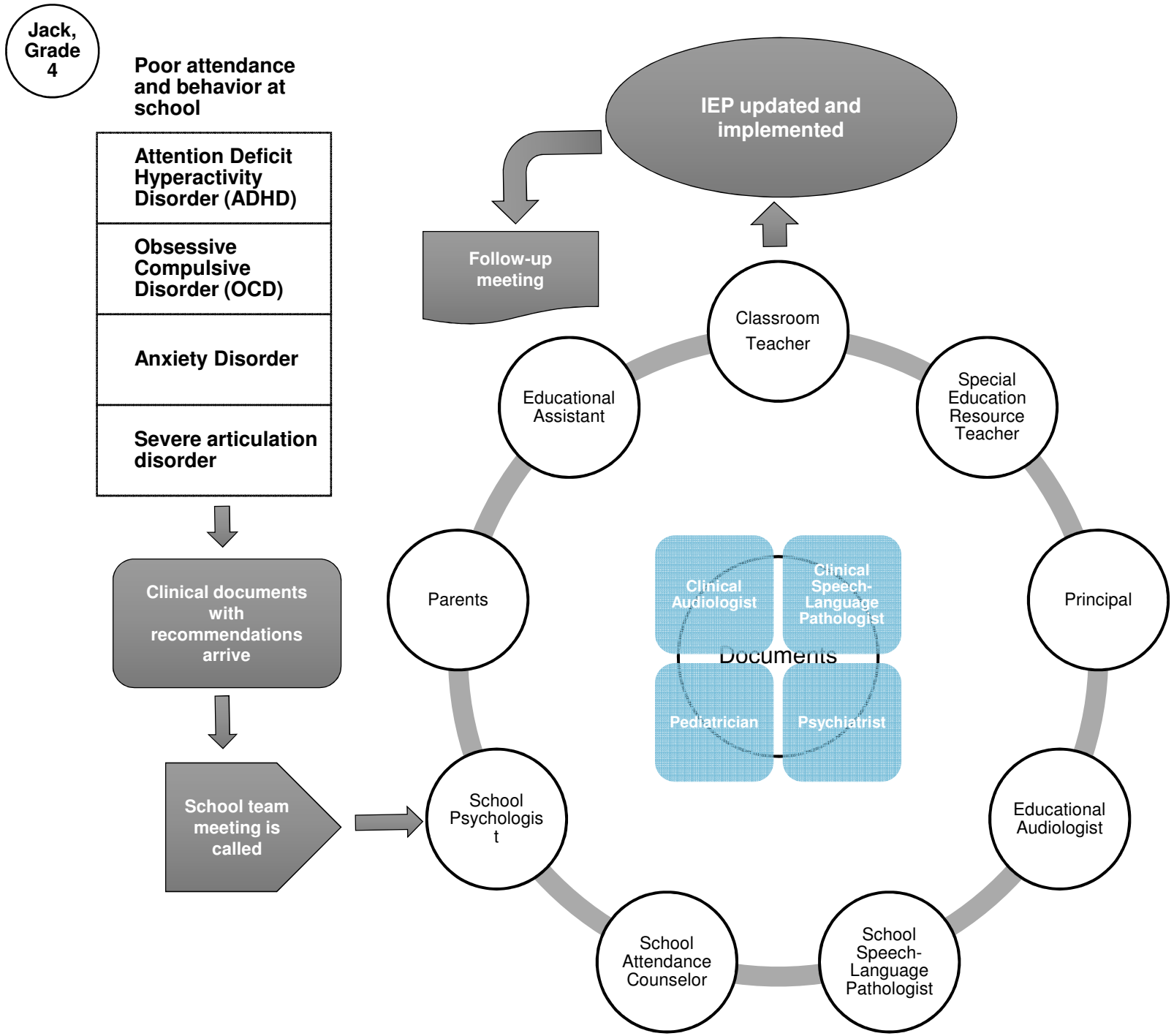
Study 1
Deconstructing the clinic-school interface for kids with disabilities

Funding Disclosure and Research Team

CIHR operating grant (MOP-130433) awarded to:

Stella Ng, Lorelei Lingard, Shanon Phelan, Sandra Regan, and Kathy Hibbert

Study context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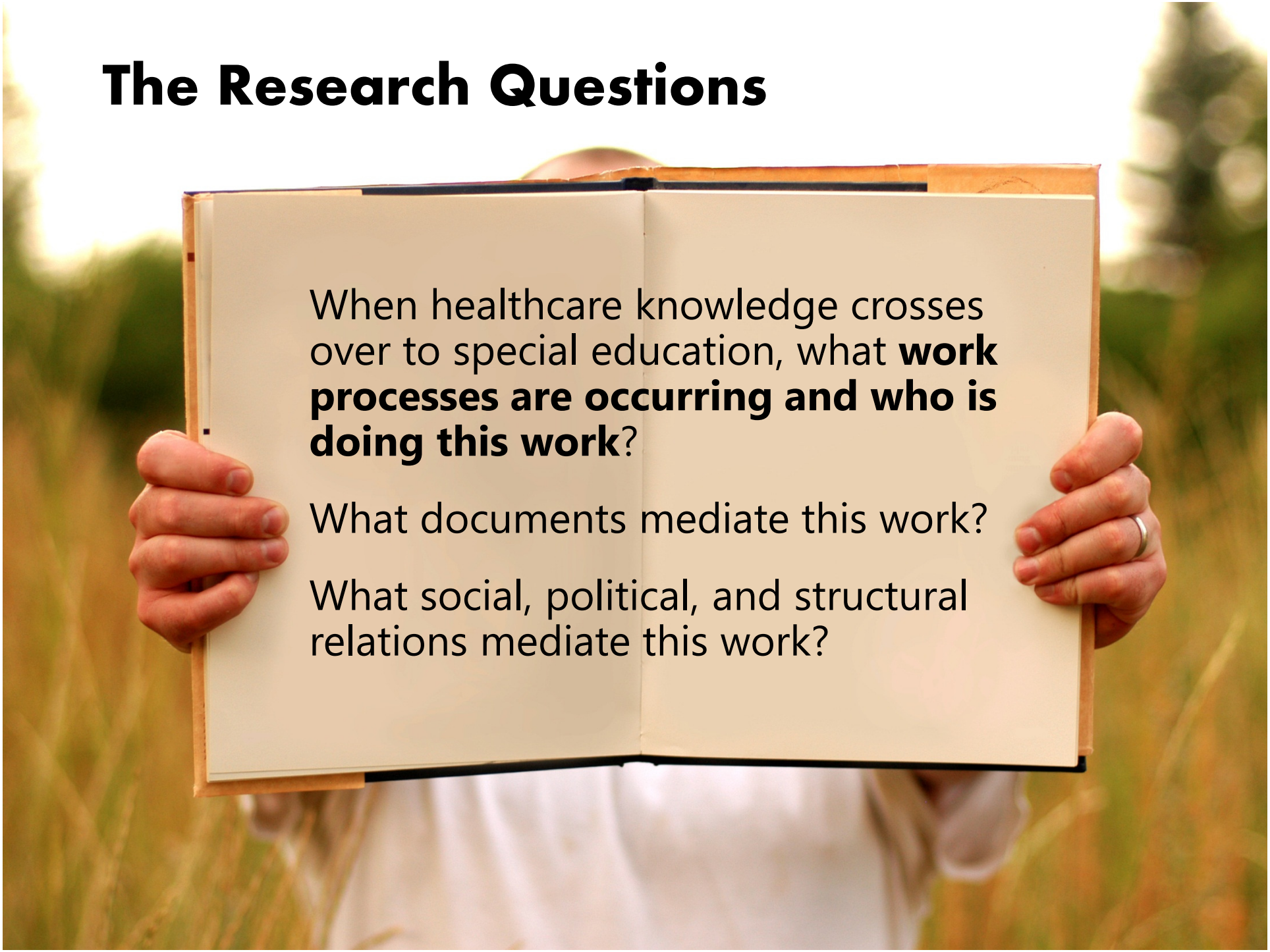
The Research Questions

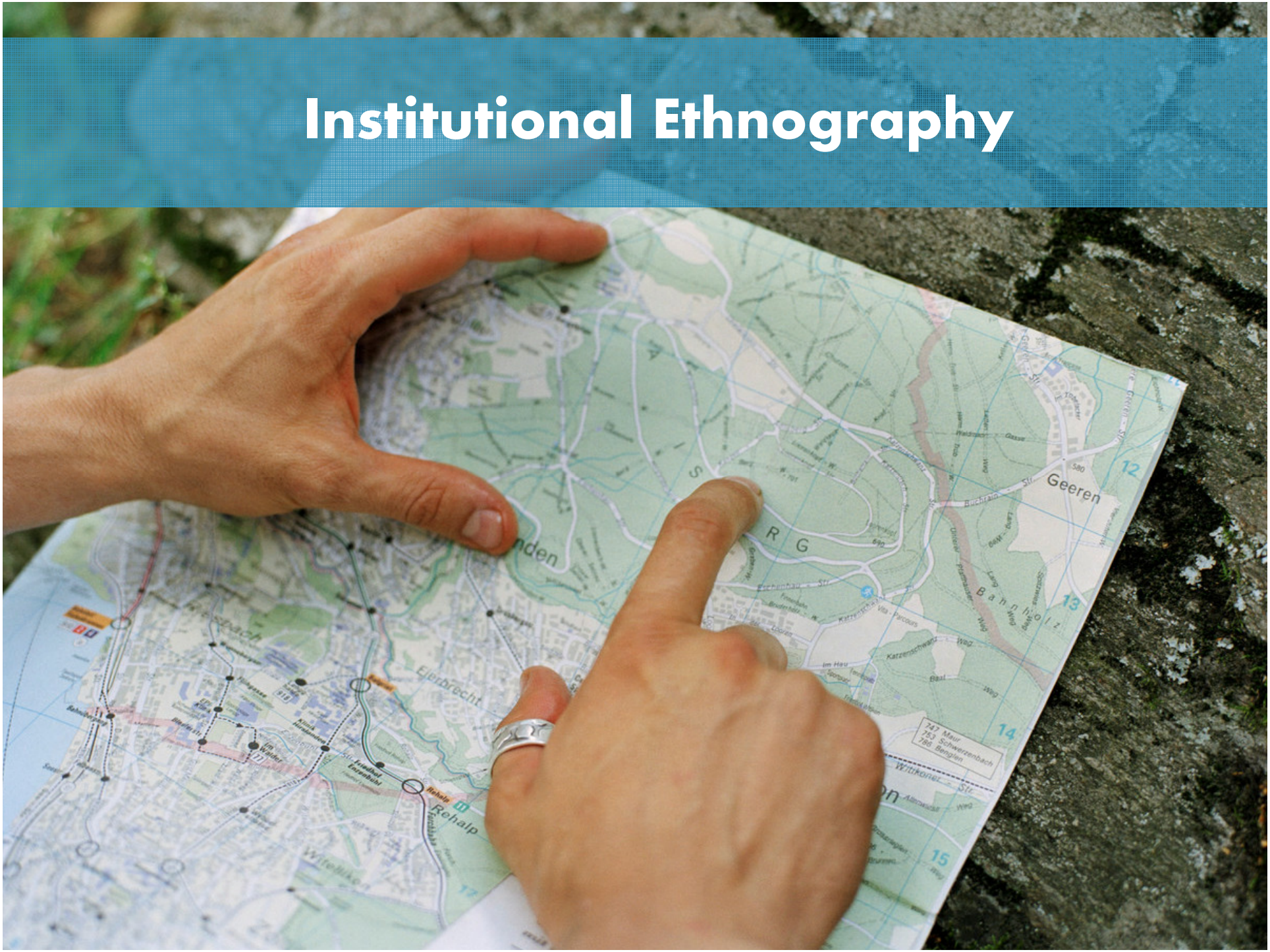


When healthcare knowledge crosses over to special education, what **work processes are occurring and who is doing this work**?

What documents mediate this work?

What social, political, and structural relations mediate this work?

Institutional Ethnography



Maps everyday **work** and **actualities** of practice from the standpoint of people doing the work every day.

Uncovers how individuals on the ground are hooked into a **wider web of social relations** – in order to enact change.

Dorothy Smith: *Institutional Ethnography: A Sociology for People* (2005)

Institutional Ethnography Analysis

Level 1 Findings

Clinicians are Spotlighting

Calling attention to particular aspects of children's needs

Espousing health advocacy as primary role in this context

More often for children with invisible/less visible disabilities and needs

Clinicians are Orienteering

Called upon to lead the way

Without a map

Self-described as naïve

Health Advocacy By Proxy

(inadvertently) burdening parents in the process

Proxies = written clinical reports; parents; others

Level 2 Findings

Coordinators of (and constraints upon) everyday work

Competency frameworks

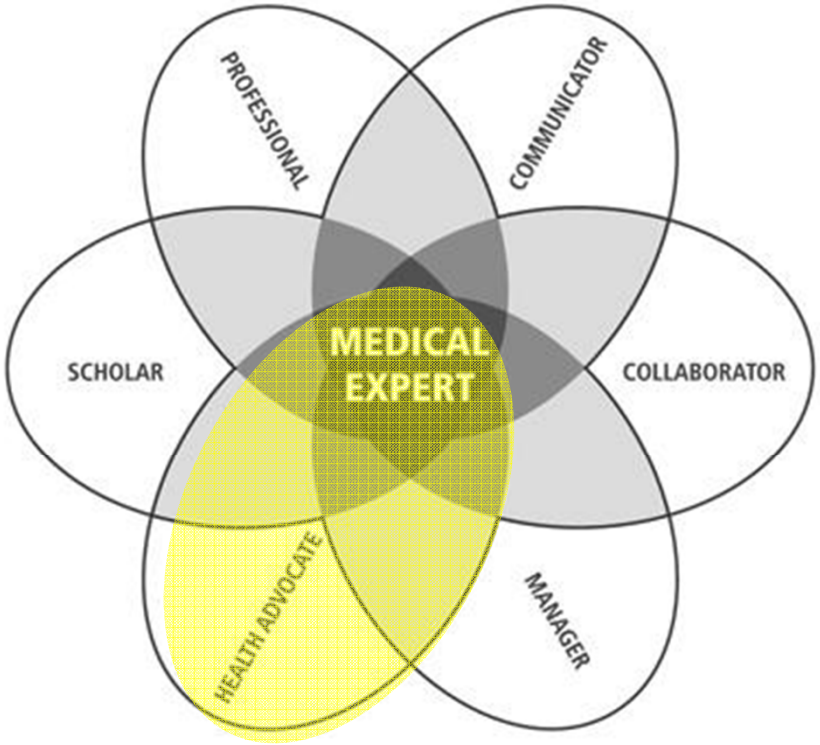
Privacy legislation

DSM-IV (DSM-V)

Professional regulations

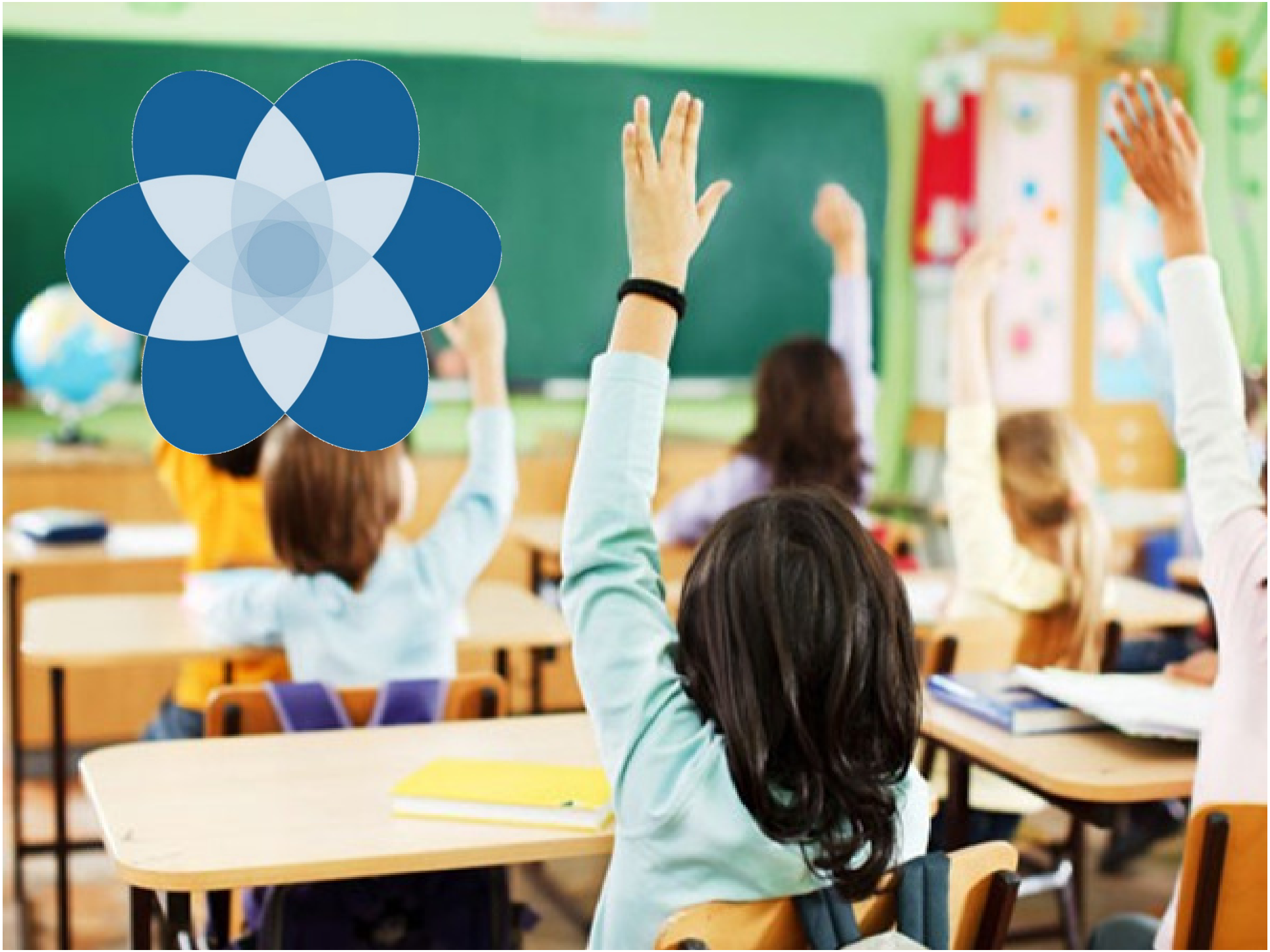
Education policies

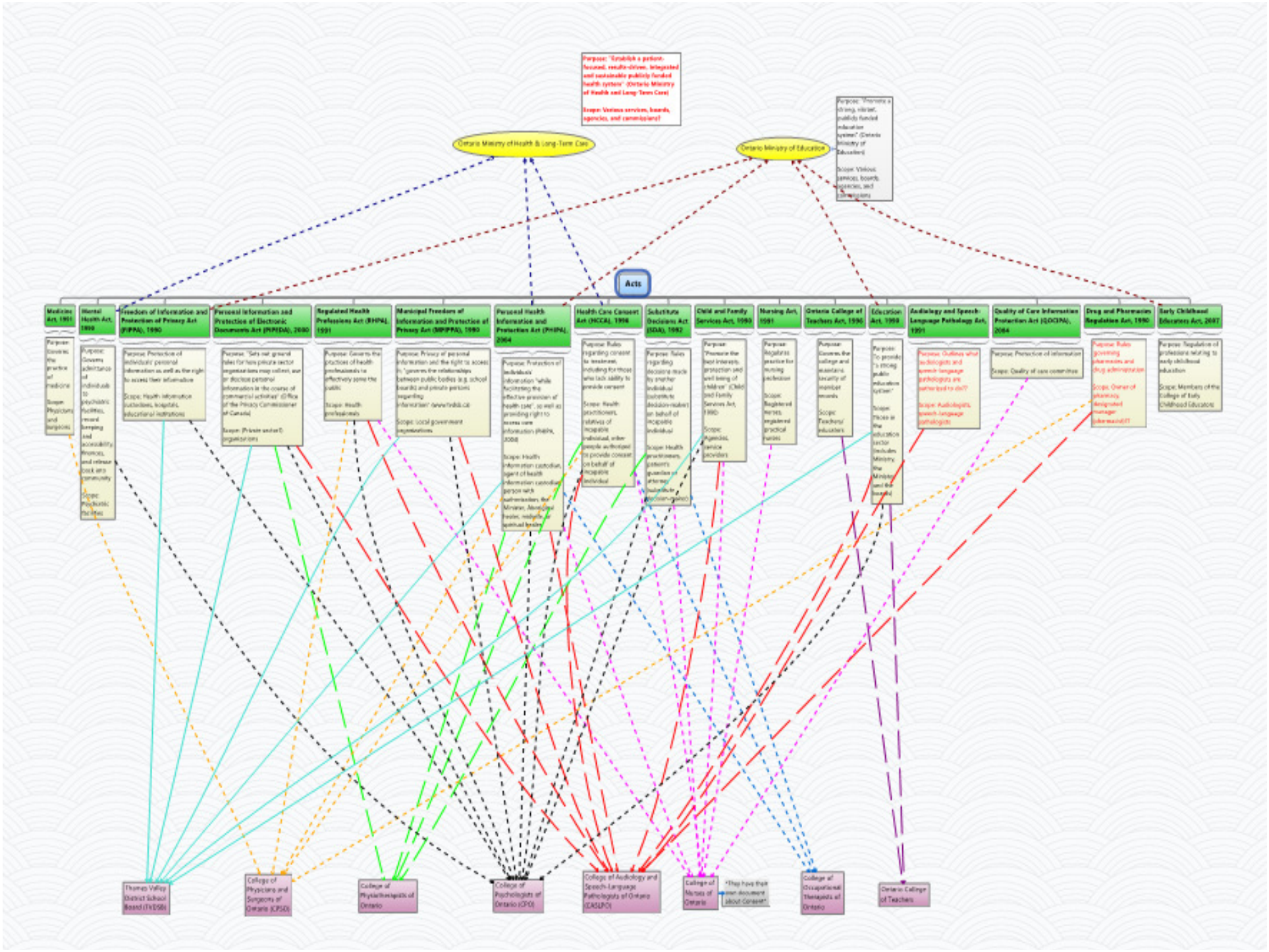
Health Advocacy



ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA | CANMEDS

"As Health Advocates, **clinicians responsibly use their expertise and influence** to advance the health and well-being of individual patients, communities, and populations."




Purpose: "Establish a patient-focused, results-driven, integrated and sustainable publicly funded health system" (Ontario Ministry of Health and Long-Term Care)
Scope: Various services, boards, agencies, and commissions
Ontario Ministry of Health & Long-Term Care
Ontario Ministry of Education
Purpose: "Promote a strong, vibrant, publicly funded education system." (Ontario Ministry of Education)
Scope: Various services, boards, agencies, and commissions
Acts
Medicine Act, 1991
Mental Health Act, 1990
Freedom of Information and Protection of Privacy Act (FIPPA), 1990
Personal Information and Protection of Electronic Documents Act (PIPEDA), 2000
Regulated Health Professions Act (RHPA), 1991
Municipal Freedom of Information and Protection of Privacy Act (MFIPPA), 1990
Personal Health Information and Protection Act (PHIPA), 2004
Health Care Consent Act (HCCA), 1996
Substitute Decisions Act (SDA), 1992
Child and Family Services Act, 1990
Nursing Act, 1991
Ontario College of Teachers Act, 1996
Education Act, 1990
Audiology and Speech-Language Pathology Act, 1991
Quality of Care Information Protection Act (QCICPA), 2004
Drug and Pharmacies Regulation Act, 1990
Early Childhood Educators Act, 2007
Purpose: Governs the practice of medicine
Scope: Physicians and surgeons
Purpose: Governs admittance of individuals to psychiatric facilities, record keeping and accessibility, finances, and release back into community
Scope: Psychiatric facilities
Purpose: Protection of individuals' personal information as well as the right to access their information
Scope: Health information custodians, hospitals, educational institutions
Purpose: "Sets out ground rules for how private sector organizations may collect, use or disclose personal information in the course of commercial activities" (Office of the Privacy Commissioner of Canada)
Scope: Private sector(?) organizations
Purpose: Governs the practices of health professionals to effectively serve the public
Scope: Health professionals
Purpose: Privacy of personal information and the right to access it; "governs the relationships between public bodies (e.g. school boards) and private persons regarding information" (www.ipc.on.ca)
Scope: Local government organizations
Purpose: Protection of individuals' information "while facilitating the effective provision of health care", as well as providing right to access care information (PHIPA, 2008)
Scope: Health information custodian, agent of health information custodian, person with authorization, the Minister, Minister of Health, minister of spiritual healing
Purpose: Rules regarding consent to treatment, including for those who lack ability to provide consent
Scope: Health practitioners, relatives of incapable individual, other people authorized to provide consent on behalf of incapable individual
Purpose: Rules regarding decisions made by another individual (substitute decision-maker) on behalf of incapable individual
Scope: Health practitioners, parents, guardians, attorneys, substitute decision-makers
Purpose: "Promote the best interests, protection and well being of children" (Child and Family Services Act, 1990)
Scope: Agencies, service providers
Purpose: Regulates practice for nursing profession
Scope: Registered nurses, registered practical nurses
Purpose: Governs the college and maintains faculty of member records
Scope: Teachers/ educators
Purpose: "To provide a strong public education system."
Scope: Those in the education sector (includes Ministry, the Minister, and their boards)
Purpose: Outlines what audiologists and speech-language pathologists are authorized to do(?)
Scope: Audiologists, speech-language pathologists
Purpose: Protection of information
Scope: Quality of care committee
Purpose: Rules governing pharmacies and drug administration
Scope: Owner of pharmacy, designated manager (pharmacist)(?)
Purpose: Regulation of professions relating to early childhood education
Scope: Members of the College of Early Childhood Educators
Thames Valley District School Board (TVDSB)
College of Physicians and Surgeons of Ontario (CPSO)
College of Physiotherapists of Ontario
College of Psychologists of Ontario (CPO)
College of Audiology and Speech-Language Pathologists of Ontario (CASLPO)
College of Nurses of Ontario
They have their own document about Consent
College of Occupational Therapists of Ontario
Ontario College of Teachers

Toward a conception of knowledge and expertise

Recognizing the limits of our **agency** and the bounds of our **structure**

Aiming for emancipation

Not from our social order, but the order of our social consciousness.

Raelin, 2007. Toward an epistemology of practice. *Academy of Management Learning and Education, 6,4.*


Once we see the inequity embedded in our ways, we can change it

Advocacy by proxy → Inequity

It's a full time job managing her. I would like to work. I can't. The schedule is too crazy […] just trying to get her what she needs, [is] a full time job. … **And I can see how if I was a different person, if English wasn't my first language**, I'm smart…if I wasn't, **I wouldn't be able to do this**.

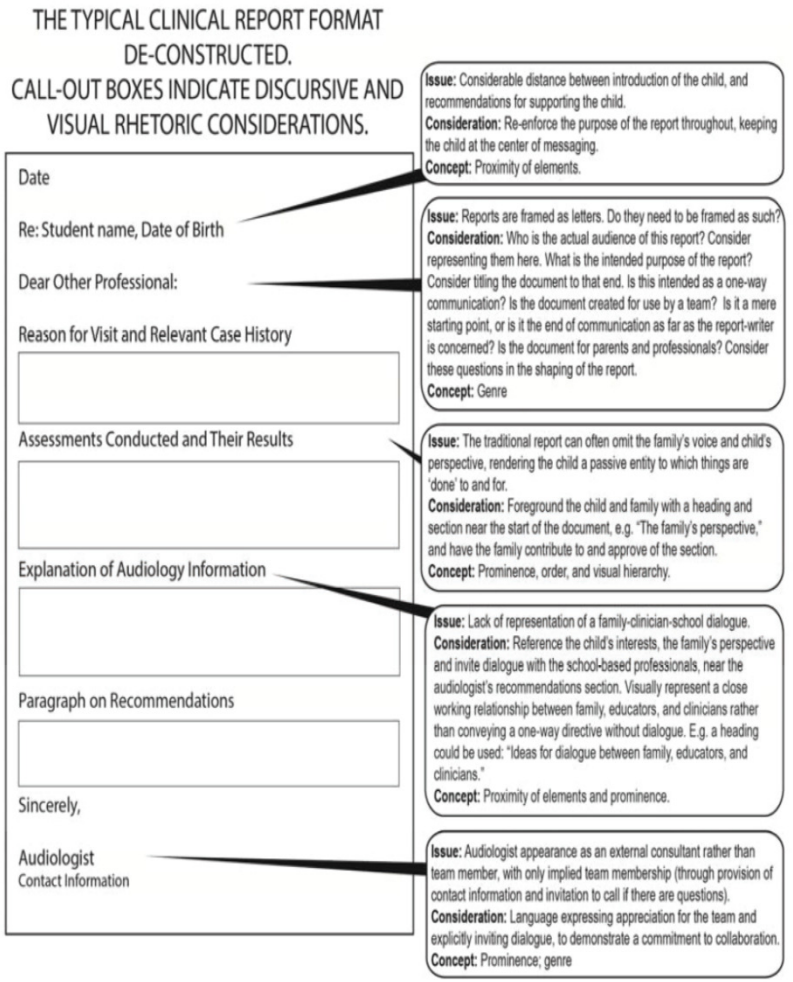
- Frances

2 examples of possible change

Re-structuring reports as agents of change

It has to be worded in a way that enables access for the child.

-Dr. Lucy



From Advocacy to Change Agency

Change agents are insightful, reflective, and disciplined

Change agents are visionary leaders and mobilizers

Change agents are knowledge integrators and translators

Change agents are diplomatic interventionists who produce meaningful outcomes.

Finlayson, M. L. (2013). Muriel Driver Memorial Lecture 2013 Embracing our role as change agents. *Canadian Journal of Occupational Therapy*, *80*(4), 205-214.

"Language **is** *social action." – (L. Lingard)*

Implications

This research challenges us to **broaden our definitions** of knowledge and competence.

To **acknowledge the everyday, experiential knowledge**, of patients and professionals, created in response to the **dynamic requirements** of our real-world environment.

Raelin, 2007

Toward critical reflexivity

Question the assumptions and ideologies underlying, and creating **structure,** in our practices.

Deconstruct the status quo of policies, dominant ways of thinking and working, and how these came to **structure** our practices.

Make way for change through change **agency**.

These findings can be found in:

Ng, S., Stooke, R., Regan, K., Hibbert, K., Schryer, C., Phelan, S. & Lingard, L. (2013). An institutional ethnography inquiry into the work at the health care - special education interface: A research protocol. International Journal of Integrated Care, 13(Jul-Sep), e033. Retrieved from URN:NBN:NL:UI:10-1-114741

Phelan, S. K., & Ng, S. L. (2014). A Case Review: Reframing School-Based Practices Using a Critical Perspective. Physical & Occupational Therapy in Pediatrics, (February), 1–16. doi:10.3109/01942638.2014.978933

Ng, S.L., Friesen, F., Maclagan, E., Boyd, V., & Phelan, S. (2014). A critical theory response to empirical challenges in report-writing: Considerations for clinical educators and lifelong learners. Journal of Educational Audiology (JEA), 20(article 3), 1-11. Available from: http://www.edaud.org/journal/2014/3-article-14.pdf

Ng, S.L., Lingard, L., Hibbert, S., Regan, S., Phelan, S., Stooke, R., Meston, C., Schryer, C., Manamperi, M., Friesen F. (2015). Supporting children with disabilities at school: Implications for the Advocate role in professional practice and education, Disability & Rehabilitation. doi:10.3109/09638288.2015.1021021

Study 2
Making sense of the audiology-industry relationship

Funding Disclosure and Research Team

American Academy of Audiology

New Investigator Award

Awarded to:

Stella Ng, Laya Poost-Foroosh, Ryan McCreery, Jeff Crukley, Shanon Phelan, Steve Aiken


Audiology
Industry

So what?

I did not attend 7 years of university to be a sales person and my nature/personality is probably the worst sales person ever! That might make me not cut out to be a clinician in private practice but my supervisor said the same thing, that she was not a sales person and she would never force a person to buy hearing aids. I think most clinicians feel this way; however, management tends to only focus on sales. It is not what I had anticipated at all, even when I was being interviewed "patient care" [was] stressed upon me; however, I felt patient care [was] the last thing on their mind. Maybe I was very naïve to the sales aspect of audiology but like I said it [was] not even a factor in the 3 years of schooling.

From Ng et al 2012 – student participant

Constructivist Grounded Theory

Purposive and theoretical sampling

Audiologists from: academia; industry; private practice; hospitals; in-training – across North America.

30-60 minute interviews

Constant comparative analysis

Findings (so far)

A range of perspectives – which most audiologists adopt – at different moments

Unavoidable
"It's not what I signed up for, but… it is what it is."

Necessary
"It's a necessity. People need to make money. And we can work well with that"

Beneficial
"It's productive; it's beneficial. It's a partnership."

Unavoidable

[…]It's a fine line, I guess, and there's not an easy solution because you have to work with an existing [hearing] aid. A researcher at a university can't produce their own hearing aids for research. So they need to get funding from somewhere and they need to purchase hearing aids.

Georgia, student

A typology of actions in the face of ethical dilemmas

What audiologists are doing

Changing the situation

Taking a stand

Justifying one's situation/making the most of things

Resigning to the situation

Denying that there's a problem to be studied/addressed

Changing one's situation

I got into trouble with my boss because my boss wanted me to sell high-end products to 95-year-olds who may or may not necessarily need all of those features. I tried to do the best that I could in order to help them get the amplification that they could use. […] Of course, it was hard for me to try to get them to buy a $6,000 hearing aid when I knew they were struggling financially. That was hard for me, and so I got yelled at for doing that as much as I did. **I didn't like it so I looked for another job.**

Francine, clinician/industry

Taking a stand

It has always guided my practice, but obviously I was not able to keep that job for a long time based on that […] I knew that it was not working for me because she did not really like the way I was working because my prescription numbers were not as high as she wished. After the first year, my contract was over, but I'm still happy I had done that, even if I had to look for another job because I have always worked with those morals. I feel that in this way I serve my clients in their best interest.

Isabel, faculty / clinician

Justifying one's situation/ making the most of the situation

At some level, there's pressure to find work, period, and I think that there might be more opportunities in manufacturer owned clinics. And I hope that that's not the case. I would prefer to be working in an independent clinic but, at this point, I don't feel like I can really rule things out. […] And I know that there are conscientious audiologists working for [hearing device company-owned clinics] and that they find a way to make that work for them. So, I think, if I had to, I could find a way to practice ethically in that context as well.

Georgia, student

Resigning oneself to one's situation

I do think a lot of people enter into audiology because of better pay and job security which is also why I think a lot of them don't care about ethics because that's not why they entered into it. Maybe I'm very cynical, I do think it's a lot of people feel that they can be a good person on the outside but they don't feel they need to think of others.

Hanna, student

Denying that there's a problem

[…]And so, I don't see a difference between a marketing claim, about patient benefit performance with hearing aids, whether I say it or whether some independent person says it because anything I say has to be based on, to some degree, independent research that has been done in the area.

David, industry

I certainly overcompensate, because I realize there is an inherent risk for perception of bias. So, I would say that I probably peg the meter too far in the opposite direction, and that's just sensitivity on my part.

Carl, industry

Being shaped by the social

Stella: What drove you to decide to try to interact with industry?

Isabel: Because I knew that they are probably our best bet to [...]I don't know how to articulate it in a more elegant way, but **I think that's where the money is.**

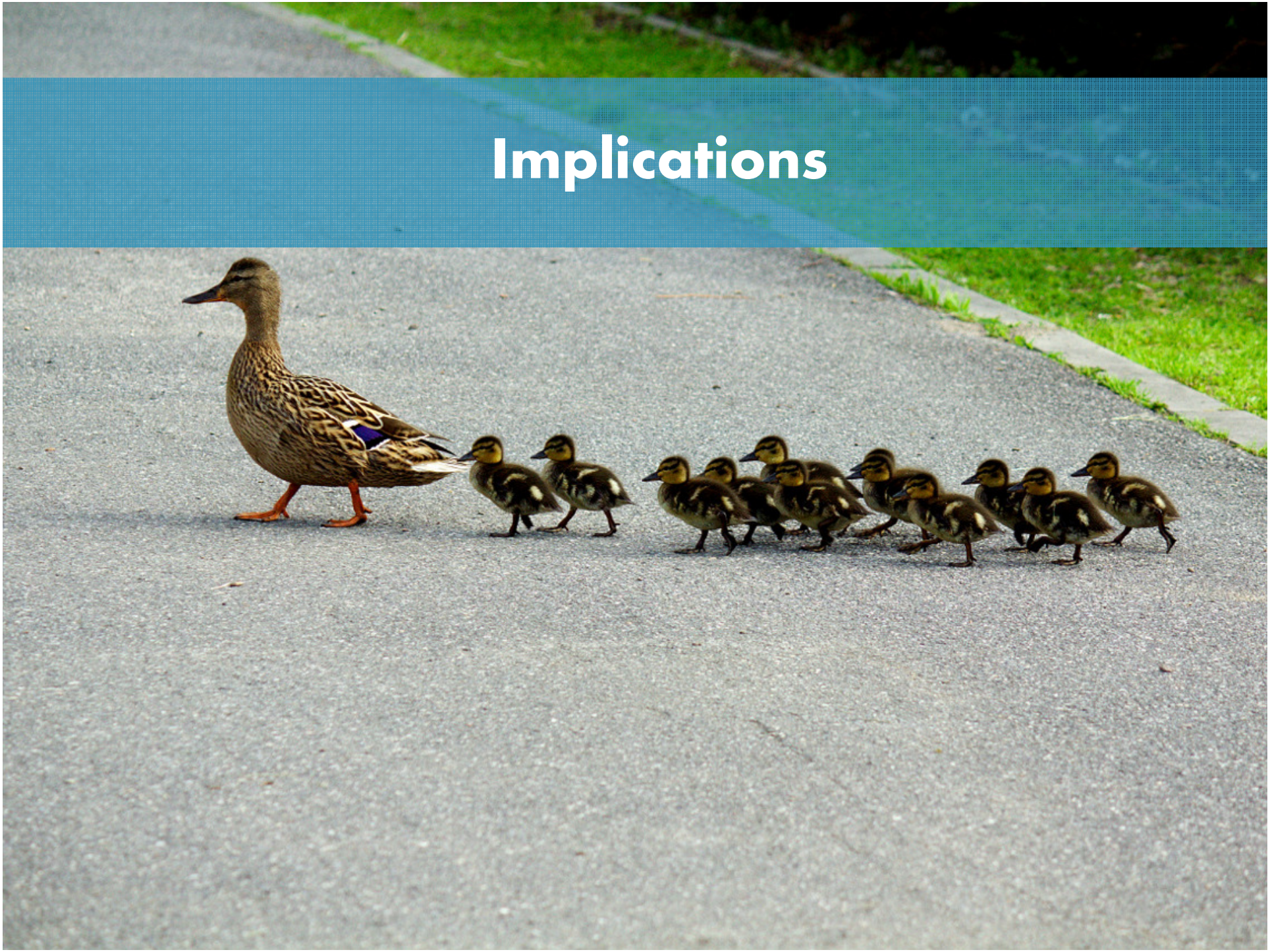
The audiologist's 'touchstone'

One example would be 'fit to target'. […] Targets are important. […] one guiding thing I use is the needs of the patients. The other thing is clarity. I always try to be as transparent as possible […].

Elliot, industry-based audiologist

1. Drawing upon the evidence
2. Doing what's best for the patient
3. Being transparent

Implications



Wrap-up

3 bold statements, demonstrated through 2 research studies

3. Expertise – framed as critical reflexivity – can and should be a goal in the health professions

Critical reflexivity for change agency

A positive way forward, with a lens of:

Noticing the taken-for-granted (social constructions, dominant ways of thinking).

Asking the tough questions about what we can do as individuals (agency), and what we must challenge at the social or systems-level (structure).

Striving for transformation, toward a better world (change agency).

Take home message

Alstroemeria
Friendship

Amaryllis
Splendid beauty

Anemone
Anticipation

Anthurium
Hospitality

Aster
Patience

Bird of Paradise
Joyfulness

Bouvardia
Enthusiasm

Carnations
Pride and beauty

From reproducing the way of the world…
Toward transforming it.

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CENTRE FOR FACULTY DEVELOPMENT

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Inspired Care.
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