NATIONAL PERSPECTIVE
PERSPECTIVE NATIONALE

• SUE BAPTISTE

Clinical reasoning: An administrator's view

Earlier in the summer of 1991, the author became preoccupied with the concept of clinical reasoning and its importance in our continuing attempts to integrate clinical service and the educational and research processes. As the climate of health care delivery becomes more and more aligned with business principles and the need to think in terms of a "bottom line", then the need for clinical departments to maximise resource utilization becomes critical. Not only is efficient and economical resource utilization a necessity, but a clear understanding of the direct service value of staff involvement in educational and research endeavours is essential. In a system under siege, the first activities to become questioned are those with an indirect connection or unclear relevance to patient treatment itself. External critics do not spend time trying to understand the connections between these functions, but rather challenge the ethical and moral right of disciplines to spend time away from obvious and direct patient care at a time when every second counts.

Clinical reasoning (Cohn, 1991; Kassirer, Kuipers & Gorry, 1982; Kassirer & Gorry, 1968; Mattingly, 1991) is a key concept of learning within academic programmes which prepare students to assume the responsibilities inherent in becoming health care practitioners. Unfortunately, it is not a concept which is perceived or recognized to be part of the natural process undertaken by occupational therapists once they are functioning in the clinical environment. In fact, it may be stated that occupational therapists do not recognize the terminology as relevant to their practice at all. Within the academic environment, clinical reasoning, together with critical thinking,problem solving, clinical decision-making and judgement (Fleming, 1991; Schwarts, 1991) are core underpinnings in any curriculum development activity. However, there appears to be a limited carry-over between the educators' utilization of these concepts and the students' understanding of the critical nature of these constructs in relation to their future practice and professional evolution (Rogers & Holm, 1991). Also, the application of these concepts to direct service delivery is minimized at best, and at worst, ignored, by busy departmental administrators and senior therapists, when waiting lists are getting longer and the flag of quality patient care is waved with increasing vigour.

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There would seem to be a critical need for the profession of occupational therapy to embrace clinical reasoning in an open and well-articulated manner in order to facilitate the understanding of the close relationship between clinical practice, education and research. We speak often in this current era, of the importance of a scientific approach to practice and the deficits within our discipline of a professional approach to our practice. Until occupational therapy practitioners can articulate their service delivery in conceptual terms, with comfort and understanding, then the integration of service, education and research will remain elusive to many clinicians in the health care and community environments within which the specialty is practised.

This author's current awareness and interest in clinical reasoning was shaped and sharpened through personal involvement in an international workshop focused on innovative methods in health professional education (University of Limburg, 1991). This workshop provided an opportunity for health

care specialists, from several disciplines and many cultures, to come together over a period of two weeks to learn about problem-based learning and to explore the intricacies of applying these principals to their individual academic and clinical settings. One of the tasks identified for small study groups to address was the consideration of the process of clinical reasoning, commonalities of its application across health care professions and the possibility of developing a model with application relevant to the cultures and professions involved in the workshop discussions.

The author was privileged to participate in such an exercise and recognized the outcome of this particular small group interaction as having inherent value to the practice of occupational therapy. The end result of this academic exercise also had applicability to the author's interest in the development of a workable and understandable model of clinical reasoning for use with occupational therapy students.

Participants at the workshop were representative of 20 countries and three professional groups; medicine, occupational therapy and pedagogy. Members of the small group in which the author was a member were from The United Arab Emirates, Germany, England, Mianmar and Canada, and represented medicine and occupational therapy as the discipline bases.

The process undertaken commenced with an open dialogue concerning the essence of clinical decision-making, in which it became readily apparent that there was a common understanding of the progression through a reasoning continuum regardless of discipline or cultural base. It was then the group's task to design a graphic representation of the theory,and the development of a model, which would accurately reflect the group's intellectual activity. Again, the apparent ease with which the group members were able to visually explain their thinking was both surprising and gratifying.

The ideas of the group were best exemplified by the concept of a spiral, as opposed to the more traditional models of clinical reasoning (Kassirer, 1976) which have been described in terms of circular processes. It was determined that the beginning of any clinical reasoning process is an ACTION, which, in turn, is followed by a HYPOTHESIS. This simple relationship is continued through a reiterative process. An ACTION can be a perception, the act of history taking, an examination, tests or treatment. With this interpretation, it becomes obvious that a natural outcome of such an intervention, or action, is the formulation of a hypothesis, which then triggers further actions, and so on, potentially to infinity.

This process, as described, will be familiar to any occupational therapist reading this article. A clinician will find herself going through these steps in a natural and often unconscious manner whenever confronted with a client or patient in a clinical setting. Occupational therapists, together with any health professional, internalize this process very early in their professional development. This becomes the very basis upon which any clinical interaction is established. Unfortunately, it becomes so innate that it loses its specific identity. Therapists tend to minimize its value or to become oblivious to its existence as a process in its own right. Reactions from clinicians tend to adopt a "so what" flavour; "of course that is what I do; it is just common sense". Not so; what is deemed common sense in fact is the seminal base for rationalizing therapeutic involvement. Consequently, this natural, adopted process can be revisited and become the best method for recognizing the close relationships between the professional educational preparation, the service role of clinicians and the vehicle upon which to build a clear relationship to research and evaluation. Since all occupational therapists can relate to the process, this can become a common ground for closer relationships between academics, clinicians and administrators.

REFERENCES

Cohn, E.S. (1991). Clinical reasoning: Explicating complexity. *American Journal of Occupational Therapy, 45*, 969-971.

Fleming, M.H. (1991). The therapist with the three-track mind. *American Journal of Occupational Therapy, 45*, 988-996.

Kassirer, J. & Gorry G.A.(1968). Clinical problem solving: A behavioral analysis. *Annals of Internal Medicine, 89*, 245-255.

Kassirer, J.P. (1976). The principles of clinical decision making: An introduction to decision analysis. *Yale Journal of Biology and Medicine, 49*, 149-164.

Kassirer, J., Kuipers G. & Gorry G.A. (1982). Toward a theory of clinical expertise. *American Journal of Medicine, 73*, 251-259.

Mattingly, C. (1991). What is clinical reasoning ? *American Journal of Occupational Therapy, 45*, 979-986.

Rogers, J.C. & Holm M.B. (1991). Occupational therapy diagnostic reasoning: A component of clinical reasoning. *American Journal of Occupational Therapy, 45*, 1045-1053.

Schwartz, K.B. (1991). Clinical reasoning and new ideas on intelligence: Implications for teaching and learning. *American Journal of Occupational Therapy , 45*, 1033-1037.

University of Limburg. (1991). *Proceedings of the Problem Based Health Professions Education Workshops*. Maastricht, The Netherlands.

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• SUE BAPTISTE

Le raisonnement clinique: la perception de l'administrateur

L'auteur communique ses premières réflexions sur la valeur inhérente du processus du raisonnement clinique pour l'ergothérapie en tant que profession à l'heure actuelle. A mesure que le climat de la prestation des soins se réfère davantage au monde des affaires et à la suprématie exercée par les préoccupations d'ordre fiscal, il devient impérieux de maximiser les ressources au sein des services cliniques des établissements de santé. Au même moment, les professionnels de la santé, en l'occurrence, les ergothérapeutes, soulignent la nécessité de maintenir une pratique équilibrée qui fait place non seulement au temps consacré à la prestation des soins mais aussi à la recherche et aux activités administratives. Afin de créer un climat propice à cet équilibre, il est non moins nécessaire que les relations entre le milieu clinique et celui de l'enseignement soient renforcées par une plus grande compréhension de l'idéologie et des besoins communs.

Le raisonnement clinique est un concept clé sous-jacent à la l'élaboration de tout programme de notre formation académique, mais malheureusement, ce n'est pas un concept qui est perçu ou reconnu comme faisant partie du processus naturel entrepris par les ergothérapeutes une fois installés en pratique. Le fait de se familiariser à nouveau avec le concept du raisonnement clinique et ses principes de base peut constituer un atout important, tant pour les ergothérapeutes que pour les professeurs; tant pour les nouveaux diplômés que pour les ergothérapeutes seniors.

L'auteur a eu le privilège de participer à un atelier international donnant l'occasion aux éducateurs et aux professionnels de la santé d'échanger sur l'innovation des programmes d'enseignement. L'une des tâches dévolues aux petits groupes de travail présents portait sur l'examen du processus du raisonnement clinique. Les participants provenaient de 20 pays différents et de trois disciplines professionnelles: médecine, ergothérapie et pédagogie. Les activités principales ont porté sur l'aspect commun de l'application des modèles du raisonnement clinique par les différentes professions et le développement d'un modèle pouvant rejoindre les groupes culturels et professionnels représentés. La facilité avec laquelle les membres des différents groupes se sont mis à la tâche, de même que les résultats illustrés par un modèle d'inspiration spirale, illustrant la continuité d'une hypothèse d'action, furent très agréables et propres à rassurer tous les participants.

Il apparaît comme une nécessité fondamentale que l'ergothérapie s'ouvre au raisonnement clinique d'une manière bien articulée afin de faciliter la compréhension de l'étroite relation entre la pratique clinique, l'enseignement et la recherche. Cet aspect prend une importance particulière dans le climat actuel des soins de santé où la maximisation des ressources est aussi nécessaire que le maintien des normes et des valeurs professionnelles.

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The National Perspective column provides a forum for members of the profession to discuss topics of national interest. The subject matters dealt with relate to the future development of the profession or deal with the occupational therapy aspect of a particular subject of importance to the profession throughout Canada.

Contributions to this column are invited by the president of the Canadian Association of Occupational Therapists. The nature of this column sometimes leads to contentious and thought provoking opinions, thus it should be noted that the opinions expressed in this column do not necessarily reflect the official stance of the Canadian Association of Occupational Therapists.

La rubrique Perspective Nationale s'occupe de toute une gamme de sujets. Le but de cette rubrique est de fournir aux membres de la profession un forme où discuter des thèmes d'importance nationale. Les thèmes traités se rapportent au développement de la profession ou à l'aspect ergothérapeutique d'un thème spécifique qui a de l'importance pour la profession partout au Canada.

Une collaboration à cette rubrique est uniquement par l'invitation du Président de l'Association Canadienne des Ergothérapeutes. Le caractère de cette rubrique peut parfois susciter des opinions opposées et provocantes. Nous tenons néanmoins à affirmer que les avis exprimés par l'intermédiaire de cette rubrique ne représentent pas forcément ceux de l'ACE.