Professional Development in Audiology: From Observation to Mentorship

Presenter: Ashley Hughes, AuD; Lori Zitelli, AuD

- [Christie] Welcome back, Dr. Ashley Hughes and Dr. Lori Zitelli. We are delighted to have you both with us again today presenting Professional Development in Audiology: From Observation to Mentorship. If you'd like to learn more about either of our guest speakers today, you can learn about them and read their course bio on the course registration page. But at this time, I'll hand the mic over to you Dr. Zitelli.

- Thank you so much for the kind introductions, Christie. Ashley and I are really happy to be here today. We've been friends for a long time, but this is the first time we've actually had an opportunity to collaborate on something like this. So what I love about this is that Ashley and I both have really different jobs, but audiology online was able to come up with a topic that allows us to both contribute information about something that we have experience with and are passionate about. So we wanna talk to you today about the relationships that we develop with other individuals in our profession, and how those relationships change over time. So I mentioned that Ashley and I have very different jobs.

You'll see our disclosures here. The take home messages are that we both work and we both volunteer. And as we talk about how our professional relationships change over time, we hope that you'll come away with the following learning outcomes. So to start, let's think about some of the ways that we can define professional relationships with other people in our profession. It's good to be considerate, thoughtful about the language that we use to describe our relationships so that they're accurately describing the situation. So we'll start at the top and go down, and then we'll dig into this a little bit more. So clearly an observer is someone who watches, this could be a high school student, an undergraduate student, maybe thinking that they could be interested in a career in audiology.

It could also be an AUD student or actually an audiologist who's trying to learn a new clinical skill. A mentor is someone who's a trusted counselor or a guide. It's really a

special relationship that develops over time, and it's something that Ashley is gonna talk much more about. Preceptor is essentially another word for a teacher. So this can be appropriate in a clinical situation, academic situation, in industry and others. A role model is someone whose behavior is imitated by others. So not only are they probably teaching things, they're modeling behavior to be imitated by those who are watching them. A supervisor is someone who's in charge of others. This can occur in a variety of contexts, and your peer would be someone who is of equal standing with you, and a colleague would be someone who works with you.

So lastly, and probably my favorite of the list is clinical instructor. So interestingly, this was not in the Merriam Webster dictionary, maybe because it encompasses a variety of things and could have multiple definitions depending on who you're asking. But the definition that I found that I liked the most was related to a description of providing clinical care, teaching clinical and other skills, completing administrative tasks and being involved with other scholarly activities. So I like this description because I think it identifies what I do the best, but ultimately you can use whatever language you want as long as it's accurately reflecting the situation. So as we think about how we're defining all of these relationships, it's important to also think about how they can overlap and evolve over time.

For instance, you may start as a student. All of us started as a student. So you may be learning from a clinical instructor or a preceptor. Eventually, you'll become an audiologist who might have students assigned to you. You'll also develop relationships with the student that may lead to you becoming their mentor, being a role model or a supervisor in some capacity. Additionally, you'll also have audiologists peers and colleagues that you'll work with and to them, you may also be a mentor, a role model, or a supervisor. So we designed the first part of this presentation to focus on student and learner relationships and given my role as the manager of the audiology

department at UPMC and a clinical instructor at the University of Pittsburgh, I'm going to focus on this aspect.

Then Ashley is gonna take us to the next level in discussing things related to peer relationships and mentorship, which is certainly something that she's thought a lot about. So I wanted to start by thinking about what to do when you have a new student in your clinic. And I really think there are a variety of things that you should consider reviewing with them as they become a part of your clinical team. It can be hard to know what you need to talk about ahead of time, and sometimes, you only find out after the fact after you experience an issue that could have been avoided. So one tool that I really love for this and that I'll share with you today is called the Placement Expectation Worksheet, which I'll outline for you on the next couple of slides.

And I like it because it helps to clearly outline your expectations of the student and help the student to frame their expectations of the clinical experience. There are specific topic areas that I think you generally should cover, but this can absolutely be modified to fit whatever your clinic's needs are. So the way that I use this is I fill out this whole form. It's like three pages long. Anything that I know ahead of time, I email it to my student before the beginning of the semester so that they can read everything and fill out their portions. And then on the first day of clinic, when they arrive, we review it together before we even see any patients.

So first, I need to know some basic information about the new student. Basically what's their name, what year are they? This helps me just to feel like I know a little bit more about them. Next we'll talk a little bit more about how we're gonna reach each other in case we need to have some sort of communication outside of the clinic. So for instance, if there's an emergency, let's say, and the student's not gonna make it to clinic because they got a flat tire, that's at the top of my mind 'cause that happened to me this morning. Sometimes things happen. In that case, I would actually prefer that

the student texts me, and this is something that I'll see immediately and then I'll know exactly what's going on.

If they email me, I might not see it right away and then I'll be wondering if they're coming, worrying if they're okay. So if we need to communicate about something that's not urgent, I think email is completely fine. Otherwise I like a text 'cause I'll see it sooner. I also ask the student the same questions about how they wanna be reached, both emergently and routinely. In cases when I may need to be absent from clinic, if I know ahead of time I can arrange for the student to spend time with one of my colleagues in the clinic. If it's kinda a last minute thing and I wasn't expecting to be out, generally I'll tell the student to enjoy their day off and offer them a makeup day.

In cases when the weather gets bad, I tell my students to come to clinic if they can get there without endangering themselves. So our clinic's in a hospital, we're always gonna be open. That may not be true for everyone and you may have specific policies about inclement weather and it's good to outline those ahead of time and what those expectations are. Lastly, in this section, there are often conferences or other professional activities that we can plan around. Usually we know about those ahead of time. So we can sit down at the beginning of the semester and discuss what our semester is gonna look like in terms of planned absences. If you have specific preferences about what the student will call you, it's good to talk about that.

So if you want the student to call you by your first name or address you as doctor or whatever else, just tell them what you want them to do. And this might actually change if you're in front of a patient. So if that's the case, also make sure you address that as well. I like to give the students some information about myself, my own experiences, including my own clinical interests and my history of supervisory activities. So I usually share a little bit of information about that with them. A lot of these students I know

before I have them in clinic, but some of them I do not. So for some students, this is our first introduction.

I also wanna know what their previous clinical experiences have been, so what placements they've had, who they've worked with, what skills they've had a chance to develop and what they feel comfortable doing already. We also like to think about some goals for the semester. Usually one or two overarching goals, and I'll come back to this in a few minutes to think about how we can do this in a way that's actionable. Then the second page is related to logistical information. So there are some things that need to be done prior to the clinical placement beginning. So for example, our AUD students at the University of Pittsburgh have to get an identification badge during their orientation at the university and students who are doing rotations at Children's Hospital of Pittsburgh need a special ID because they're going to be in contact with vulnerable populations.

So that all needs to be done before they even come to the clinic on the first day. So if there's anything like that, you'll wanna address that. We also review what the schedule is gonna look like kind of in general. So specifying what time I want them to arrive, what time they should expect to leave, as well as discussing what attendance expectations look like during holidays and school breaks. So our clinic is closed on some holidays and although students are not required to attend clinic during school breaks, they can if they want to. So we specify the beginning and the end of the semester so that I know exactly which weeks I should be expecting them as well.

This specific issue attire is kind of less of an issue since we switched to wearing scrubs, but some clinics may have a dress code that needs to be followed for all observers and practitioners and learners. So if that's the case, it's good to specify for the student and also provide them with a copy of the dress code if needed so that they can ensure that they're meeting those guidelines and what they're wearing to work. I

like to ask my students to bring a little notebook that they can keep in the pocket of their scrubs and they use this to write down information that they need to remember during appointments. Like if a patient said something specific that they wanna remember to put in the progress note or keep track of their clinical hours or interactions for the days and write down any questions that they might have.

We have a variety of other clinical and office tools that they're welcome to use in the clinic, but that's really the one thing that I ask them to bring. I think it's a good idea to talk about what the students should do related to meal activities during the day. So usually for clinic, with me, it's a full day and my students typically pack their lunch because our days are often really busy. We do have some cafeteria and kiosk options in the hospital, but a lot of times we don't have large chunks of time available to us that will allow us to take advantage of them. So we do have several appliances that the students know they're welcome to use.

We have a refrigerator, a microwave, coffee pot, those kinds of things and I always make sure to point out the location of the restrooms so that the students don't have to ask about it in case that might be uncomfortable for them. I think it's very nice to introduce the students and observers to anyone else that they come across in the clinic and that includes audiologists, students and sometimes particularly the front desk staff, because a lot of times students are interacting with them to try to figure out if patients have arrived and what needs to be done in order to get patients checked out. This section provides information related to what we will actually be doing during the day and how to know what that is.

So the student needs to know where to find my schedule when they come in. They need to know how to read it, so they need to look at the appointment types to see what kinds of appointments we're expecting and then prepare for that by locating any ear molds or hearing aids that we'll be delivering, printing previous audiograms, et

cetera. So if a patient cancels or no-shows, then there are a variety of other activities that we can do during that time, like helping to check in the mail, hearing aid repairs. If there's a walk-in patient, we can help with audiogram coverage for our otology clinic or if they have something specific that they wanna practice or discuss, we can always do that.

I'm a little bit fussy about staying on time. I get stressed when I'm running behind. So I tend to ask my students if we're in that situation and they have questions to hold them until we have downtime. So this is again, like one of the reasons I like them to have that little pocket notebook. So even if we don't have time to discuss something immediately following an appointment, we can do it when we have downtime. Our students are all required to maintain documentation related to the number of hours and types of clinical competencies that they're recording. So we make a plan for me to sign those hours and then the last page is focused on the clinical learning activities that they'll be having during the semester.

So we talk about the specific appointment types that they can expect to see during that rotation with me and what their typical day will look like in terms of like we see patients from this time to this time, then we typically have lunch, then we do this with the rest of our day. I also like to explain my expectation that as the semester progresses, I want them to move toward independence. So for the first couple weeks, I'm okay with them hanging back, but I also wanna encourage them that if we're doing something that they feel comfortable trying, they should jump in. Toward the middle of the semester I want them to push themselves to try new things and have a little more autonomy in making their own decisions, and then by the end of the semester, I want them to take the lead at most of the appointments, really trying to take ownership of the patient and getting to the point where they're able to present their plan to me for approval or discussion.

The last part of this form is related to the ways that I like to give feedback and the way that the student prefers to receive feedback. So there have been some students who have asked for consistent feedback after each appointment when it's possible. Others have asked for a small short debrief session at the end of the day where we can kind of talk about everything, and there have been others who have wanted an email summary at the end of the day so that they can use it for reflection after the fact. So whatever the student prefers is what I try to do for them, and there's really a whole range there. So I had previously mentioned a goal setting as something that we want to include in our Placement Expectation Worksheet and I think SMART goal format is a really nice way to do that because it creates a plan that's actionable and specific.

So SMART's an acronym. It stands for specific, measurable, attainable, relevant, and time bound. And here's an example of how you could use this framework to help your student make a SMART goal for their rotation with you. So first we need to make a specific goal. So this could be something like, I will independently take 10 thorough and appropriate case histories during a tinnitus consultation appointment. So here the student is specified not only the number of appointments that they wanna complete independently, but also the specific skill that's a part of this specific appointment type. So you can see when you're getting this specific, you could have many, many SMART goals for a rotation. One way to measure that this specific goal is completed is to have the students fill out a case history form.

So if they have difficulty, they're gonna learn to ask clarifying questions or reword questions if the patient has trouble answering. So for attainable, I would help them to determine whether this is attainable for them, and in this case, yes, I think this is a good goal. In terms of relevancy, it's relevant for audiologists because we need to be able to evaluate and manage tinnitus complaints. This is in our scope of practice. We are absolutely the best practitioners to be providing these services and then lastly, it needs to be time bound. So in this case, we've determined that this deadline will be the

end of the spring semester, and that really gives us an endpoint to keep in mind as we progress toward that time.

You can also add a few other components to make your goals SMART-ER. So SMART goals should be evaluated over time, that's the E, and this helps to make sure that they don't get pushed into the background and kind of forgotten about, 'cause it can be easy for that to happen and they can also be readjusted, so there's your R. For some reason if you discover that you're not meeting your goal, you can readjust it, try a different approach, maybe think of some new ways that you can try to attain it. We've been talking about progression of clinical skills over time, and there are really several models that illustrate how this happens and how it typically unfolds.

So I chose a few here to highlight as I think this is just important to think about when you're working with students and moving them toward independence, because I like the strategies that I'm highlighting because a lot of them provide specific strategies to think about to facilitate this progression. So the first one we'll discuss is Anderson's Continuum of Supervision. Under this model, there are really two components. There's supervision from the clinician and participation from the learner. So when the student is new, they are going to require a hundred percent supervision because they won't know anything and over time, as the student becomes more capable of completing some portions of the skill themself, the amount of supervision can decrease and the amount of participation will increase and ultimately the goal for the student is to participate a hundred percent with 0% supervision when they're practicing autonomously as a clinician.

So here are some illustrations of a few time points that students can progress through using this model. So here I'm working with one of my students who is displaying an emerging skill. So we're talking about how to make a recommendation related to hearing aid technology. So she's new at this, she really needs constant direction. You'll

see I'm sitting very close with her and we're looking at the paper together and in this example, I might be teaching her this is the specific hearing aid style that we should recommend for this patient and X, Y, and Z are my reasons for this decision, really laying it all out for her. The next stage is when the skill starts to emerge, but kind of inconsistently.

So in this case, the student will require ongoing guidance, but they still have some freedom to try some things on their own. So you'll see I'm still sitting at the table with her, but I'm a little bit further away. So she's really discussing these options with the patients. I'm giving her a little bit of space. So in this case, I might tell her when the patient has a question, I'll be here if you need me, I'm here to answer it and can do that for you if you're not sure what to say. Next, the skill emerges most of the time. So in this case, I'm still in the room with her, but I'm no longer sitting at the table with her.

I've created even more physical distance so that the patient will hopefully talk to her rather than talking to me. That always happens when I'm sitting at the table with my students. So physically removing myself is, I've found one of the best ways to address that and let the student take control of the appointment. So here I'm listening actively, I'm watching and I'm ready to jump in if there's something that's missed or if some information is not presented in a way that's appropriate. So I may, in this case, interrupt and say, let's explain that in a little more detail and talk more about why the hearing aid style they're asking about is maybe not the most appropriate for them.

Here, my student is displaying a skill consistently and capably. So I'm in the room, but my attention is divided. So I'm working on something else in the background while I'm listening to her interactions with the patient. So if she needs me, I can help, but I'm not right on top of her and I'm not really actively listening to every single word she's saying. So I might tell her I'm listening, I can jump in if you get stuck, just let me know. When a student is displaying a skill and showing that they're independently competent, we

work together to make a plan about how we're gonna manage that patient's care. So we collaborate and I provide feedback about their contributions.

So I might say something like, I think this is a really good recommendation for this patient, and I agree with your choice and lastly, when a learner is demonstrating that they can perform a skill exceptionally, we really have a collegial relationship. So we might even ask each other for advice in this case. This happens all the times with my current externs, whenever a patient is interested in a model of technology that I'm not that familiar with. Our externs work regularly with everything, so I can always ask one of them, it's really nice. So I feel comfortable saying to my externs much of the time after we've discussed what we're gonna do, I like your plan. Let me know when you need me.

Another way that you can interact with learners is using what they call the One Minute Preceptor framework. So using this strategy, you can focus the interaction that you're having on trying to teach them something in a very short period of time. So the steps are as follows, and we'll elaborate more on the next slide, and Ashley, I'm hoping you can help me a little bit with this next set of things. So the first step is to get a commitment from the student. We are gonna probe for supporting evidence, reinforce what they did well, give a little bit of guidance about any errors that they might have made, and then end with teaching a general principal. So, Ashley, are you here with me?

- [Ashley] Sure, I am.

- Okay, so we're gonna pretend that Ashley is my second year AUD student. Thank you, Ashley. So we'll pretend that Ashley's just tested a patient and I want to find out a

little bit more about her thought process as we try to find a diagnosis. So we'll go through an example now of how we could use the One Minute Preceptor strategy with students. So the first step is to get a commitment. I'm gonna ask her what she thinks is going on. So the idea is doing this makes the process more interactive and it encourages the student to integrate the information that they have available to them so far. If they're correct, it's a really good opportunity to provide positive feedback, good reinforcement, and if not, it's a teaching moment and by making them make the commitment initially, the thought is that the lesson is more likely to be impactful because they have originally made that commitment.

So Ashley, what do you think is going on with this patient that you've just tested?

- Well, I've been thinking about it for a while. I think that maybe the patient has otosclerosis.

- Okay, so now we have a commitment, so let's find out how she reached it. We wanna encourage our students to develop some solid clinical problem solving skills and reasoning skills, and it's awesome when they arrive at the right answer, but we really wanna know how they got there. So I would ask Ashley, what are the factors that you were considering in this history and the physical exam that are supporting this diagnosis that you've given?

- Okay, well first, when I asked about the onset of her hearing loss, she told me she first noticed hearing loss in her right ear about six months ago when she was laying down in bed. When she was laying on her left side. So she specified her right ear was up. She noticed that she couldn't hear the TV as well, and it got more and more noticeable over time. She also reported experiencing occasional tinnitus in her right ear that isn't very bothersome. When I looked in her ears, they were both clear. I didn't see

anything abnormal, everything looked visible and intact. The test results showed normal hearing in the left ear and a moderate conductive loss in the right ear.

So one possibility is middle ear effusion, but I didn't see any fluid bubbles. Like I said, when I did otoscopy, it looked good. No amber fluid or redness to suggest any otitis media. So I thought otosclerosis was the cause of her gradual hearing loss. Plus she told me she has a history of single-sided hearing loss in her family that was fixed with surgery.

- Now, well done, Ashley, thank you. I wanna take a moment to reinforce what Ashley did very, very well. So I'll provide specific feedback that's gonna show her that I value her skills and her ability to communicate that information to me. So I might say, Ashley, your diagnosis of otosclerosis is very well supported by the history that you took, your physical exam and by your test results. So I might say you did a good job of integrating the information. Otosclerosis can be bilateral, it's often unilateral, and it does develop gradually over time, as you said. So, although you didn't see it today, you may see a reddish tint when you look in their ear. This is called Schwartz's sign.

It's thought to be indicative of bony changes that occur near the cochlear promontory and there is often a genetic component. So you mentioned she had a family history, you may have patients reporting that they have multiple family members who had surgery to fix their hearing loss, and this may be particularly true in women. So then, now that I've told her what she's done particularly well, I also need to point out any areas that might need improvement. So I wanna be as specific as possible and identify things that can be improved in the future. So I might say, Ashley, you did mention that she has a conductive hearing loss, but you didn't mention the tympanogram results and it looks like we don't have tymps.

So in the future, anytime you have a conductive or a mixed component on the audiogram, you'll wanna assess the status of the middle ear. So let's go do tymps. So if we do tymps and we find that they're normal bilaterally, let's think about how these results can fit into the puzzle that we have. So lastly, we wanna teach a general principle that they can apply to other situations that are similar. So I might say osteoporosis is a stiffening of the ossicular chain that raises the resonant frequency of the middle ear. The probe tone we use for tympanometry in adults is very low frequency and it, a lot of times, can't identify osteoporosis especially when it's a very early stage.

So in this case, tymps are normal and that's often the case in osteoporosis which is really not what we would expect when there's a middle layer pathology. So this is one of the clues that you can use to help us arrive at the correct diagnosis, which you did. So it's just something else that you can add to your list of reasons why you think osteoporosis might be the right diagnosis. So I really like that strategy because it's quick. It's something that you can do kind of on the fly and you can be helping students and teaching as you go, and you can do that multiple times in a day. The last model that I'll talk about is called the SQF Model.

It's called the SQF Model of Clinical Supervision and it provides preceptors with practical ways to integrate supervision, questioning and feedback. That's the S, the Q and the F into clinical learning environments and the goal is to support the student in becoming a clinician that is autonomous. So we wanna give them good reasoning skills and help them to develop those. The goal is purposefully using situational supervision and strategic questioning while you're providing feedback that's consistent to move them toward that independence. So using this strategy, the type of supervision that you provide needs to be based on the situation and the clinical situation really has four components. So the first component is gonna be the learner. So that's gonna be their knowledge, their skill, their experience, their motivation.

Those are all things that will play here. The second component is the task that the learner's trying to complete. The third is the urgency with which the task must be completed and the fourth is the consequences to both the learner and the patient if the task is not completed accurately or within the appropriate timeframe or whatever the constraints of the situation are. So keeping all of these factors in mind, you can work toward tailoring your supervision to whatever specific situation you're in. So a student who will have differing developmental levels depending on what their knowledge, experience, motivation, et cetera, levels are. So a student who's, what they call a D1 learner, is someone who's incompetent and I know that sounds like kind of a mean thing to say, but what they mean by that is that the student either doesn't know what they don't know, meaning they don't even know what to ask, or they realize that there are things that they don't know and that there are things that they need to improve upon.

A learner who's at a D2 level is someone who's competent but needs to kind of spend a lot of energy and effort to do things correctly. So they really work towards doing things the right way, but they know what to do. A D3 learner is someone who is what they call unconsciously competent. So this is someone who doesn't need to expend a ton of effort to complete whatever the clinical task is. They've done it many, many times. They just don't have to think that hard about it. So those are the the learner developmental levels. There are three possibilities in terms of supervision style as well. So these are essentially three snips from the Anderson model that we discussed earlier.

So the S1 style means that you're standing essentially right beside the student, you're providing consistent support and making sure that you're very close with them. S2 style is being close enough to provide help if needed, but far enough to create a little bit of space and give the students some autonomy. So if you think back to my examples from Anderson's model, I'm in the room, I'm sitting behind her, kind of letting

her drive. And then the S3 level of supervision would essentially mean, you've got this, come get me if you need me, I'll be over there. The questions that you use for each situation range from Q1 to Q3. So I'll briefly describe them here. Q1 questions are asking students to recall information and identify knowledge.

So kind of basic level what questions. Q2 questions are things that require the student to apply a higher level of thinking. So, so what, so what does this mean? So it might require them to compare two things or more, analyze information, synthesize, apply information in different ways. And then lastly, Q3, the most complex and advanced level of questioning is what now? Meaning what are you going to do with this information? Essentially, what is your plan? So this requires them to evaluate all of the information that they have, make a plan and defend whatever their clinical decisions are. And then lastly, as you go through this whole process, you're meant to be providing pretty consistent feedback the whole time.

So there are a couple of different ways to do that. One way is to provide corrective feedback in which you're trying to prevent them from developing bad habits and you don't in stopping them from sharing information that's incorrect. Or you could be using a strategy where you're kind of guiding them toward other possibilities and helping them to rethink if the path that they're on is not the one that you want them to go down. So now using the SQF Model, let's pretend like Ashley is a D3 student. So again, a D3 student is one who is unconsciously competent. She doesn't have to think too hard about what she's doing. She's done it many times, she's advanced.

So for whatever the task is that you're doing, she's an advanced student and I do think that's an important distinction because you can have a student who's a D3 student for one specific task and a D1 student for another task that they've maybe never seen before, or only done once. So it really is situation specific. So in this case, for the task that we're doing, let's say Ashley's a D3 student, and I wanna use a Q3 question or a

more advanced question to evaluate her ability to make a plan for treatment and then defend her clinical decision making. So let's think about what an appropriate question might be for this level of student. So I'm gonna throw some out and we'll see what we think.

So one possibility could be to ask, Ashley, how do you calculate pure tone average? So in my opinion, this is not a great question for a D3 student because it really just requires the student to identify some foundational knowledge. They need to know how to do simple math. They need to find the average of three numbers. They need to know the three frequencies that they need to be looking at, and they need to know that it needs to be air conduction thresholds. It's really not a Q3 level question. So what about this one? What frequency probe tone do we use for adults for tymps? Again, to answer this question, the student really has to recall a fact.

They just need to spit out a number 226 hertz. They don't even need to know why or why this is important in this situation or why it might be different for children. It really doesn't require them to apply any higher level thinking. So again, not a great question for a D3 student. How do you administer the QuickSIN? So in this case, the student can absolutely recite a list of steps or actions to answer this question and they may do that without having any idea what the QuickSIN is or what information it gives you or how to administer it if you sit them in front of an audiometer. So it's really asking them to list steps and not requiring them to synthesize anything.

So I don't like any of these questions. A question that I think might be appropriate for a D3 student would be something like, why did you decide to use broadband noise as the stimulus for your patient's tinnitus sound generator? So I think this is a good D3 question because it requires the student to kind of evaluate what they know about the patient and their diagnosis and their audiogram and everything that they've been told about how their tinnitus is impacting them and defend their clinical decision making

skills. So hopefully, a D3 student in this situation would say something like, I chose to use broadband noise because the patient reported that when they use a white noise machine at night, it helps them to not notice their tinnitus as much and I also know that white noise is kind of a neutral sound that doesn't have very much meaning, and it's easy for our brains to habituate to and those kinds of answers would all be appropriate for this kind of thing.

So that would be a good Q3 question, I think. So I also like this model because it's specific to the specific situation, the person, the task, and you're using questions to move people toward higher levels of thinking. So this is another strategy that you could implement as well. So ultimately, our goal for these students across all of the competencies that we're assessing is clinical entrustment. So entrustment literally means progression of competencies. We're entrusting them to do these things themselves and to provide this care. So we wanna see them progressing and moving over time toward clinical independence, improving their confidence and their decision making abilities. I think there are multiple ways to measure this, but one that I saw that I liked was being taken from a surgical training resource and it ranges from one to five, with one being I had to do everything myself.

The student did absolutely nothing. I had complete hands-on the entire time, to two, which is I had to talk them through what to do. The student was able to do things, but I had to really give them some pretty consistent direction. Three being I had to prompt them from time to time. So the student is demonstrating some independence, but they required some direction from time to time. Four, being I needed to be in the room just in case. So they're pretty good at the skill, but they're not aware of all of the risks and still require some supervision for safe practice and five being the other end of the spectrum, or I didn't need to be there at all.

So the student is completely independent, autonomous, understands all the risks and is safely performing the task. So even if you're not formally assessing your students in this way, it can help you. A tool like this can help you to gauge their level of independence for specific tasks and tailor your feedback to them and as you interact with them and also to their universities, as the universities are asking for feedback as well. So I love these pictures because these are two pictures that were taken during one semester. So the picture on the left is from a clinical skills lab that I was teaching. It's the first ear impression that my student made and you'll see the material did not reach the OTA block.

She was a little bit too slow in mixing it. So by the time she actually started to push it out of the syringe, it was largely hardened. So that's why it looks like that and then by the end of the semester, with some guidance and some practice, she was able to safely and successfully create an ear impression that shows us all the landmarks we want and was a safe procedure. So ultimately, again, this is our goal for all of the tasks that we're trying to teach our students. So from here, I'm gonna pass this over to Ashley and let her talk a little bit more about what happens after we get the students to the point where they're independent and autonomous practitioners.

- Awesome, thank you, Lori. There we go. Thank you very much for sharing all that information about precepting with us and I agree precepting is great and can be even better with some structure. Precepting is also not the only way to give back and help shape the future of our profession. I, for example, don't really have the opportunity to be a preceptor in my role. I work in industry, but I still really love to give back and help grow the profession. Mentorship is something that I'm very passionate about. I feel very lucky for the mentors that I've had in my professional career so far, and the

mentors that I still do have and I love having this as a way that I can give back to our profession.

So we'll just start with a basic discussion about what mentorship is and mentorship can look very different, but generally it will consist of giving advice, providing guidance, helping to make contacts or networking, sharing experiences and using coaching skills, and we talked a little bit about what other types of relationships exist in the workplace, but I'm gonna specifically talk about what differentiates mentorship from some of these relationships like coaching, precepting, and managing. Mentorship can often be confused with some of these other relationships, and it's understandable 'cause some of them can seem very similar, but there are differences between them. So coaching, as an example, is performance driven. It's designed to improve the professionals on the job performance.

Unlike coaching, mentors offer advice and guidance, but the mentee chooses whether or not to implement the advice. Managing is very different, it's a directive command with the goal of achieving specific results and objectives. Sponsors, if you've ever had a sponsor before, a sponsor typically will help you advance while a mentor will give you ideas on how you might advance. A sponsor is typically in a leadership position, and a person can only truly be a sponsor if they're able to create an opportunity for you that you wouldn't have access to on your own, and that really isn't true for mentorship. And so what is true for mentorship? Unlike coaching, it's more development driven. We're looking not just at the professional's current job function, but beyond, taking a more holistic approach to career development.

Unlike managing a mentor's key role is to transfer knowledge of specific information. So mentoring provides guidance and assistance and enables the supported individual or the mentee to find problem solutions, or to find solutions, excuse me, through asking direct questions. Unlike sponsoring, a mentor advises versus advocates. So we can

see that even though mentorship is different from managing, coaching, precepting, all of those things, it does involve some of the same things, but it's approached in a more collaborative way. We'll talk a little bit about what it takes to create and cultivate a meaningful and successful mentorship relationship. The most important thing to have and foster in our relationships are mutual trust, regular contact, belief in the process, and a desire to grow.

Realistically with the right pair, if they're both engaged in the process, it honestly can be pretty simple, and we sometimes overthink what it takes to really build and grow a successful mentorship relationship. I'd also like to talk a little bit about some mentorship myths. So understanding these misconceptions can help us open our minds to relationships that we might not have seen possible before. Oftentimes, people are under the mindset that the mentor has to be older or more senior than the mentee. A mentor is more experienced and skilled in certain area and is willing to guide others. But experience shouldn't be confused with age or seniority. I've been mentored by both individuals older and younger than myself, and I've served as a mentor to individuals both younger and older than myself.

Someone can only be a mentor or a mentee is another common one. It is possible to have experience in one domain while lacking experience in another. So for example, I mentor some people on things like relay measurements, but I have a mentor for some things like wideband tympanometry. It's possible and even recommended by many to be both a mentor and a mentee. Wearing these dual hats can increase your appreciation of the other partner in both of those relationships and sometimes if you're lucky and your mentorship relationship lasts long enough, you'll even trade spots in that same relationship where sometimes you're the mentor and sometimes you're the mentee. Mentoring is for people who have not been successful, that again, is just simply not true and the opposite is true actually.

Mentoring is a tool for development and development is not just for people who are falling behind are people who aren't as successful. So some of the most highest, or some of the highest performing professionals actively seek out mentorship and guidance. The mentor dictates the relationship. Again, a mentoring relationship is based on mutual trust, respect, and openness, so it's really a partnership. A mentor's role is to provide perspective, challenge your thinking, and provide support and encouragement. The mentee also needs to bring their views and experiences for this to be worthwhile. So the mentor should really be actively seeking feedback from the mentee, and they should acknowledge when they don't have the answers, and that's perfectly acceptable to say, and the last one is, mentoring is time consuming.

Mentoring does require dedicated time, which can be daunting because everybody is already very busy, but dedicated time doesn't have to be time consuming and there are ways to kind of set those boundaries at the beginning of the relationship, and we'll talk about that a little bit later. So, why mentorship? People seek it out for a variety of reasons. Not all of them are listed on this slide, but we really have two main factors, internal or external. Regardless of why you're seeking it out. Mentorship will often provide value both personally and professionally for growth and improvement. Mentorship relationships can also provide specific benefits to employees and to the workplace and a lot of these do also carry over to personal benefits.

So overcoming diversity issues in the workplace, being part of succession planning for an organization, improving employee engagement and loyalty, reducing high turnover, onboarding and new employees. Those are all times where you might see a workplace have mentorship set up. And so we'll just talk a little bit about some of those tangible benefits to mentees. In a literature review on mentorship, the following things emerged as benefits for mentees. Increased career advancement and higher salaries. Something that audiology as a profession definitely seems to want to push towards. Increased job related wellbeing, confidence and improved work-life balance, excuse me, work-life

balance and increased career aspirations. So those are the benefits to the mentees. The benefits to the mentors, again, from the same study found employer recognition, increase in networking opportunities, increased confidence and personal satisfaction, and decreased burnout and I can say from my personal experience as a mentor, that is definitely true.

I leave these relationships and meetings with these people feeling excited, meeting new people that I otherwise may not have met. So hopefully, I know we haven't talked too much about mentorship, but hopefully we've started talking about it and now you're really excited to get started, but you're not really sure how to get started. The nature of the relationship really matters more than how it started. So it can be formal or informal. So assigned or unassigned. I've been part of workplaces before where we had mentorship opportunities where you were paired with somebody based on a questionnaire that you filled out. It can be peer to peer. So there are times where I will reach out to Lori, and Lori will be my mentor.

She's not my assigned mentor, but she's providing guidance to me that helps me figure out what I want to do. There's also other examples where it can be assigned, such as volunteering with the student organization and serving as a mentor and then another thing is that it can be initiated by either the mentor or the mentee. So sometimes these relationships will form organically. So for example, Gale Whitelaw is somebody who I consider a mentor. She's never been assigned to me as my mentor, but our relationship just formed and it grew over time. But then I have some that I personally initiated. So an example of that would be wideband tympanometry. I really needed a mentor on it and so I approached Gabby Merchant, who is very well known for her research and her clinical work on wideband.

It was our first time meeting and I literally went up to her and asked her to be my mentor, and so we've had quarterly meetings since that date. And although that might

seem like an awkward way to meet somebody, it's actually blossomed into a wonderful friendship and I'm learning so much from her. There are some things that are helpful to discuss when you're en entering into a mentorship relationship. Having these discussions upfront can avoid frustrations and ensure everyone's entering the relationship on the same page. I think of this similar, of course it's different, but I think of it similarly as the Placement Expectation Worksheet. But now instead of for the preceptor and the student, it's for the mentor and the mentee.

One thing that makes this a little bit different is this would be more of a discussion instead of each person just stating what their expectations and preferences are. And these kinds of conversations can help ensure that you're a good match before you both devote a lot of time into it. The reason I came up with these is because these actually came up by a recent mentor of mine. We went through all of these things and it really helped us make sure that we knew what we were getting ourselves into and whether or not we both had the bandwidth to support the other person and what they needed to get out of it. So how often can you meet?

Is everybody expecting monthly, quarterly, weekly, preferred meeting platform? Do you wanna do a video call? Is it an email touch base phone call? Expectations from each other. That can be things like, if you're going to cancel, I would appreciate this much notice. Long and short term goals. What is the purpose of the relationship? Are you trying to learn more about, we'll just stick with wideband tympanometry with the goal eventually of eventually co-presenting at a show. Or kind of what are you hoping to get out of it and what are you hoping to learn and gain? So now you've decided that you wanna be a mentor. What can you do with your time to make sure that you're as impactful of a mentor as possible?

Loyalty is extremely important. Of course, we all get something out of these relationships, but we don't enter them looking to get something out of it. We always

want to speak in a positive way about our mentees. So kind of praise in public, criticize in private, have those discussions privately because there's a level of trust that you're gonna keep those things private and you should be aligned on what you're trying to get out of this relationship. We don't really wanna be working alone, we wanna be working together. So you show them how to do something or vice versa. It's not us telling them what to do, but instead it's working together to achieve these goals. Give them the tools that they need to succeed.

So equip them with what they need to succeed. Like I said, we should be leaving these meetings excited. When I'm meeting with my mentors or my mentees, I leave these meetings kind of with a similar feeling that I have when I leave a conference. I'm full of energy and I am excited about our profession. There has to be respect and it has to go both ways, like any other relationship for it to be successful. We wanna teach and learn together. This isn't a one-way street with the mentor teaching the mentee and the mentee doing what the mentor wants, but instead we're working together and we're growing together. Provide constructive criticism and make sure that you're mindful of the way that the person likes to receive criticism and the last one that I think is really nice is your mentor or your mentee, it can be discipline agnostic.

So it's really important to think about what your goals are before you just run out looking for a mentor or a mentee. It doesn't necessarily have to be an audiologist. If you want a better understanding of the inner workings of hearing aids, maybe an engineer would be a good mentor. If you are interested in being mentored so that you're kind of primed for a leadership position, anybody in a leadership position could be your mentor and it really could open your mind to some things that you wouldn't necessarily get with an audiologist. One thing to keep in mind is that there are boundaries in a mentorship relationship, just like any other relationship and we wanna make sure that we're always being respectful of the other people's boundaries, even if it's different than our own.

So the boundaries that you have or that the mentor and the mentee have might be different from each other and we really need to try and understand them. So there could be differences in your cultural background, your gender, your age, your life experiences and chances are there are going to be differences in at least one of those categories. So make sure that you're entering these relationships with an open mind and open communication to ensure that both parties feel safe, secure, and comfortable in the relationship. That's only gonna help grow your trust and ensure success. A lot of people get stuck at the point of, I want a mentor or I want a mentee, how do I go about finding one?

For somebody like me who's very extroverted, the first option might be easier, but just put yourself out there and ask. Chances are the person will say yes if they have the bandwidth and if they say no, it's not personal. You can do it by offering to help with practice interviews as a way to kind of forge a relationship with people. Or if you have a friend or a colleague that is very well networked, use them and ask them for recommendations for people within their network. It's really the strength of us having a small profession is even if you don't know somebody, I promise that you know somebody who knows somebody who would either be looking for you as a mentor or who would be able to find an appropriate mentor for you.

If your state has an audiology or a hearing organization, oftentimes there are mentorship programs through those or from some of our national organizations. So on the slide I've just listed a few of the states that I know do have opportunities for mentoring students through the state organization, and again, this can be discipline agnostic. So you can volunteer or serve as a mentor for a non audiologist. If you go to your university alumni or any other sort of group or organization that you're part of, and when you're choosing your mentor or your mentee, how do you know if somebody's gonna be a good fit for you? There are some things that you can look at ahead of time

that will kind of help you find the right person and of course, like anything else, some of it you find out in a relationship.

For values, you really wanna make sure your values align with the person that you're going to be working with. That can help lead to a a stronger relationship. You wanna make sure that the person in mind is able to communicate in a way that works for you and in a way that you're able to understand. So you can do this by observing how they interact with other people. Do they convey their feelings or their ideas with ease? Do they communicate with others willingly? These are really important things to look for because your mentor will only be able to communicate with you as effectively as they're communicating with others. But also these kinds of interactions can help you become a better communicator.

In order to teach anything as a mentor, the person has to be willing to help. So just because someone is successful doesn't mean that they're going to necessarily be a good mentor. So before asking someone to mentor you, try to get to know them a little bit first. I know that's counter to the story that I just shared about myself, but have lunch with them and see how open they're about talking and sharing about their successes. Like we talked about, you're gonna wanna make sure that you clearly define what you're looking for in the relationship between you and your mentor. So have an idea of how much time you wanna spend with them, your preferred communication, what activities you'd like like to partake in together.

Do you wanna shadow them? Do you want time to ask them questions outside of the professional setting? Inquire about those things before committing to a specific person and make sure that you're being very clear in your expectations so that we can make sure we're entering this relationship on the same page, and personality is definitely something that needs to be considered when you're choosing a mentor. That does not mean that the mentor and the mentee need to have similar personalities, just

compatible. So if you're an introvert and your mentor is the opposite, you might find yourself uncomfortable, or maybe that would work out really well. So just trying to get to know them and overall, this match comes down to compatibility.

So it's important to note that some of these relationships will form organically, not an official ask, but in those relationships it's still important to keep these things in mind. Hopefully everyone here has been fortunate enough to have a mentor or two that's significantly impacted the trajectory of their career, and same for preceptors. We hope that you're leaving this talk feeling equipped to be a stronger preceptor or a student and a stronger mentor and mentee. If you haven't yet had the opportunity to serve in these types of roles, we hope this talk in encouraged you to kinda take that next step after this. And as I like to say, when talking about a variety of things related to our profession, a rising tide lifts all boats.

So let's all try and be that for the next generation of our profession and for each other. Okay, and now we're just gonna take some time and see if we have any questions.

- I choose to believe we've thoroughly answered everything.

- Lori, one question is, how do you recommend preceptor, like somebody who's new to precepting? Do you have any advice for them as they're kind of entering their first year as a preceptor?

- I work with a lot of colleagues who are new preceptors. A lot of times, if we have an open position, we find that one of our externs wants to stay on, and there is a period of time where they're required to wait before they can be assigned a student officially. But I do work with a lot of our newer... I kind of try to mentor some of our newer colleagues and think about different ways that they can interact with their students, different activities that they can do, thinking about questioning, all the things that I talked about.

So I think if you can find a mentor who can help you to be a better preceptor, that is the way to do it.

All right, if there are, oh, it looks like maybe we have one question. Oh, someone thanking us. Thank you, Margaret, we're happy you were here.

- Thank you so much for taking the time to join us. If you have any questions following this, feel free to reach out to either Lori and or myself, and hopefully we'll interact with all of you soon.