CLINICAL PERSPECTIVE IN FIELDWORK

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1.0 Introduction

One of the objectives of the TTTI's is to bring about changes in the Technician Education System : to improve class-room teaching by the teachers; to better curriculum management by the HOD; institutional management by the Principals; & State level educational planning & management by the Directorate. For the past twenty years, TTTIs laid emphasis on long term courses, and short term courses for educating & training teachers in better methods of teaching & curriculum processes. When one evaluates the impact of the TTTI's programme on the functioning of the polytechnics & the state directorates, one finds little change in these organizations. It is now clear that merely imparting knowledge & skills in educational technology & curriculum development to teachers alone does not automatically motivate the trained teachers to adopt new ideas back in their jobs in the polytechnics. They need further assistance on the job by a consultant who is capable of diagnosing the problems in all its dimensions which an innovator faces in the organization, whether he is a teacher, a head of the department, a principal or a Director of Technical Education. Such type of consultants are called by various names in social science fields : clinician, organization development consultant, process consultant etc. We will call such a consultant as 'Clinician' in this article. The purpose of this article is to emphasize that TTTI faculty should also take upon itself the role of a clinician and follow up of the TTTI educated & trained key persons in the polytechnic system to provide further assistance on the job in carrying out innovating work which may lead to better students learning. But this role requires that the TTTI faculty acquire more specialised skills of a clinician.

An attempt is being made in this article to describe these skills. The idea being expressed is drawn from the monograph : Schein Edgar = Clinical Perspectives of Field Work, 1988, New Delhi/New York : Sage Publications.

In social sciences, two major categories of researchers working in the field are understood -- 1) a Clinician, variously also designated OD Consultants, counsellers, process consultants, clinical psychologists etc. & 2) Ethnographers.

Edgar Schien in the above monograph explains the roles of a clinician by comparing & contrasting them with the roles of an ethnographer. This, he says, is necessary because, many times, these specific research activities are lumped together & vision of the specialised role of a clinician gets blurred. Following sections will describe the roles both of clinicians & ethnographers bringing out distinctly the contrasting & common features of each.

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2.0 Scientific Knowledge Vs Experience :

There is a gap between what we know as the 'scientific knowledge' in disciplines like organisation psychology, sociology, anthropology etc. and what we know from our experience as the member of the organisation and as the helpers and consultant assisting these organizations. Scientific theories developed by the scientists cannot be used in practical situation unless they are understood & interpreted in the context of these particular situation obtaining in the organization.

Clinical research has a legitimate place in filling this gap through the field oriented research in individuals, groups & organisations. A clinician has the goal of assisting an organization facing a problem, in solving that problem, he, therefore, must develop rapport, gather data, analyse it & communicate the results of his research to the client, for which he needs to possess high level of skills. He has, therefore, to undergo professional training & acquire a license to practice. As a professional, he has to maintain certain ethics to ensure the confidentiality of the transaction to avoid harming the interest of the organization with which he has worked.

3.0 Initiation :

Clinician is a person who has been educated & trained to get involved with an individual, group or communities/organization in a 'helpful role'. Such consultants are usually invited by the client to enter the organization for solving a problem of the organization.

Ethnographer, on the other hand, is a person who first selects a 'subject' i.e. person, group or the organization as his research site. He has already selected his problem on the basis of his research interest in his discipline. He must create his own 'entry' situtation in the organization & is not invited by the organization unlike a clinician.

4.0 Model for Intervention :

The clinician starts with an 'action research' in which he assumes that the clinician cannot understand a 'human system' unless he tries to change it through his interventions. Notwithstanding the organizational chart & job description of individual & teams, the actual activities within an organization is essentially invisible to a passive observer. The clinician has a model of how to improve the situation and has to bring about the change within a certain given time frame. He, therefore, intervenes at appropriate places in the organization with diagnostic or provocative questions, interpretations, suggestions & recommendations in order to elicit a response from the client. The nature of this response becomes the primary diagnostic data for determining what may really be going on in the organization. Clinician's interventions, therefore, precedes or is simultaneous with the diagnosis. The clinician rules out gathering data by merely observing 'what is out there' occuring in the organization. He believes in willfully eliciting & analysing responses from the client by stimulating such a response & observing how the client relates himself to their outsider i.e. the clinician.

The ethnographer model of enquiry is different. It is built in the assumption that the organization exists outside the consciousness of the ethonographer & can be observed & deciphered without perturbing its functioning by deliberate interventions. The ethnographers are not supposed to change the system he is observing. If he needs, he can only purturb the organization a bit to elicit responses for observation & interpreting.

To sum up the above discussion, in the clinician's model, the initiative is taken up by the client system who needs help, sees problems & wants to cope better with tasks, and want some relief from some undesirable conditions. The process of consultation stops when the problem is solved.

In the Ethnorgraphic model, the researcher himself initiates the research enquiry, seeks out an organization and uses his energy to get entry, form relationship, elicit interest & motivation from the client. The problem is already defined by the ethnorgrapher as his research topic for which he has entered the organization to collect data.

5.0 Psychological Contract :

Both the clinician and the ethnorgrapher enter the clients/subject's organization with a certain psychological contract. Psychological contract means the unspoken expectations between the client and the searcher which define what behaviours will be considered normal or abnormal, good or bad, success and failure. Such psychological contract between the two operate right from the outset and is determined by the past experience & their stereotype of what certain type of relationship imply. As the relationship unfolds during their research or consultancy activity, these psychological contract gets revised in a complex way.

In the clincial relationship, the client expects to pay fees & expenses to the clinician for which he expects to gain improvement & help in a defined problem area in the organization.

In the ethnographic relationship, the 'subject' is expected to give ethnorgrapher access to various organisational settings, make introductions to the various members of the organization and expect to get the knowledge of research results from the ethonographer which the 'subject' can use for improvement in his own organization. 'Subject organization' expects ethnographer not to be too obtrusive & not to ask embarassing questions which migiht disturb the existing process seriously. Ethnographere is expected to pay his own expenses. Ethnographer is expected to do his research to understand the organizational dynamics as it exists.

In clinical model, the thrust is on solving a problem rather than merely understanding organization as it exists. Ethnographer endevour to understand the organizational process and its culture. It is not for helping them in solving the problem even if in the process of research he notices the existence of a serious problem within the organization.

6.0 Common Characteristics

There are certain common characteristics both types of researchers possess.

First, both are active inside an organization and both are entitled to take outside help for their research.

Second, both of them must learn to be alert to the fact that various elements in the organization might attribute false motives to them, misunderstand their expertise & expect some thing which these researchers cannot always give.

7.0 How each Researcher's Prespctive affect data gathering & analysis:

Clinical perspective is orinented towards the concept of health & pathology, towards problem areas needing remedial action, towards dynamics of change and improvement. It is normative in its orientation and the clinician draws onthe theories that provide normative direction : concepts of

health, effectiveness, growth, innovation, intergration & the like. The clinician also filters data on the basis of his experiential background of the cases he had handled earlier. Thus both the problem statement & his experiential background determine what data he will collect & how he will analyse them.

Ethnographer, however, has his own preferred concepts and categories & theories determined in light of his own research problem & use them for gathering & analysing data. He will return frequently to his research agenda than to theories of health & their solution. This focus forces him to study the organizational event in a broader context of the situation to enable him to derive better generalizable theories related to sociological & social psychological themes.

On the other hand, the clinician is interested in psychological themes, interpersonal themes, group theories & those portion of systems theory that will deal with system health & the process of improving its health.

Clinician is, thus, limited to the problem areas and consequently limited in breadth. But he is more likely to get more 'indepth' knowledge of the situation he is studying because he can ask embarassing questions to his clients to elicit vital information & also confidential information connected to the problem area & thus gain deeper understanding of what is really happening in the organization & why it is happening. He explores motives & intention of the members, groups, and the organization itself. Ethnographer is more concerned with the completeness of the total situation, its context, related matter & how things work generally at a considerable level of detail, but may miss how a particular process works in detail.

8.0 Who learns more :

As stated earlier, the clinician gets more indepth knowledge of the problem-situation than the ethnographer. Since the enquiry is initiated by the organization itself, the clinician is more accessible to the higherups in the hierarchy in the organization. The psychological contract enables the client to deliberately & consciously reveal data. This psychological contract does not exist between the ethnographer and the 'subject' organization. He, therefore, tends to get information from the lower echelons of the organization.

The information received from these two sources do have essentially asymetrical basis, in that both obtain different levels of information. Understanding the views of the higher-up reveals the cause of organizational events throughout the organization more quickly & in greater depth, while the one received from the lower level is of restricted nature & can give data about the feelings & prejudices of the lower category of staff.

Given this assymetry, both the ethnographer & clinician's data should work in a complementary way if one really has to understand any organization.

9.0 Scientific Validity :

Scientific discussions which ethnographer aims to achieve are validated on the basis of the replicability of findings, of its internal consistency & credibility. Ethnographer can improve the credibility of his findings by giving the feed back of his data collected & analysed to his subjects. But it is difficult to achieve this because of inbuilts prejudices & fears of the 'subject' groups which are affected by such findings. Internal consistency is achieved by maintaining objectiveness & logic. This is also difficult to maintain because of the interpretive nature of

the analysis of the data. Thus the only condition for the validity of such discoveries is its replicability & this is possible. A student of any culture can tell a person who is about to visit that culture, a great deal of what he can observe there & indeed the predicted things will happen.

In case of clinicians,findings of his study of a particular situation cannot be replicated & hence replication is difficult criteria. His very presence in the organization brings about changes in the situation i.e. in beliefs, assumptions, attitudes & knowledge & skills of the client. For the clinician, the ultimate test of his knowledge & findings is whether or not he can predict the result of a given intervention. Such occurrence of a predicted responses in the client system validates their theory or model of what is actually happening. This validation of the findings is dynamic organizational process itself & depends not on replication but the successful prediction of intervention results. The ultimate validation of his findings is the improvement in the problem-situation itself for which the clinician is employed. However, achieving emprovement does not itself reveal causal links of the events that lead to improvement. They are revealed by further gathering of data or postmortem in case conferences or other settings.

The best use of clinical data is in the construction of varibales & theoretical models of organizational change. The clinician learns about the most fundamental dynamics in the organization even though they are not provable. If the clinician happens to be in the right place, at the right time when the critical organizational events take place involving key factors in the organizational drama, one has the basis for theory construction which may then be validated with other case material & ethnorgraphic infomration. The power of the clinical work is that it provides better varibales & better understanding of the system dynamics than the other research methods & these must be more utilized in useful theory building in disciplines or fields of study listed below.

10.0 Professional & Ethical Issues :

The clinician is typically trained in theories that focus on models of pathology & health, effectiveness, coping dynamics & interventions. These theories come from pathology, clinical psychology, applied psychology, sociology, anthropology, organizational development, social work etc. that focus on changing & improving human systems.

Ethnographers typically are trained in description of how the existing social systems work; often explicitly rejecting normative theories on how the systems should work. Such theories come from sociology, anthropology, political science, social psychology.

Both ethnographers and clinicians have to learn to observe, listen, develop relationship with client subjects, to elicit information during conversation, interviews & use structured devices to gather information.

But the use of these devices are totally different from one another in ethnography & clinical work, because each has different goals to achieve. Clinician uses these devices for diagnostic purposes to elicit information about health & pathology & introduce processes to bring about organizational change. The ethnographer will act as a camera & use these devices to just record of what is going on with the minimum bias on what should be the focus in the organizational events.

Both the clinician & the ethnographer do field work. But the clinician is likely to get training in the context where the people have

problem to solve & need some treatment or education. Ethnographers learn to live with the natives (so to say) as they are. For organizational clinicians, the applied training ground is often human relationship workshop where sensitivity training & other activities are used to improve insight & skill of the participants through a variety of experimental exercises of activities with the student clinician in a helping & coaching role.

For ethnographer, being helpful is not a primary goal. The main goal is to be minimally obtrusive, to be accepted comfortably so that they are invited to attend more & more activities of the group being studied & become participant observer.

The clincian can ask confronting questions so long as they are seen to be helpful. The Ethnographer has to be careful in asking questions to avoid confrontations. In fact, he may have to learn how to cope with confrontative behaviours of his 'subject' to prove his trustworthiness and sincerity.

Clinician, in his helpful role, has the power to advise & make suggestions. He must learn to make his suggestions more responsibly. Ethnographer does not have to learn this skill, but must learn to quickly understand & decipher the kind of things the 'subjects' may attribute or misattribute to him. Only then can they remain in the organisation/field to carry out his research.

The formal training process for the clinician should be to have atleast master's degree / Ph.D. level education. Further they must be provided with an internship through residency or practice & must be designated as consultant.

The ethnographer, on the other hand must have typically Ph.D. level programme involving a year of field work providing practice in gathering & analysing data in the field followed by a publication/thesis in relevant scientific journal. He should be designated as a researcher. The credentializing is done through granting of tenure by the academic institutes that heavily involves academic peers, but rarely the community.

Clinicians must learn to communicate with the potential client, whereas ethnographers with their subjects and academic peers.

For the clinician, to translate the insight into a scientifically valid information is a secondary skill. For ethnographer, to learn to understand his clients problems is a secondary skill. It is these secondary skills that prove to be generally a real challenge, because in the organizational work the two roles many times blend into each other.

Both clinicians & ethnographer have committment to scientific objectivity and spot distortions occuring in the data being collected & correct these distortions.

Both these have the responsibility of not missing the information they have obtained during their fieldwork for personal gain.

Both the researchers must understand the consequences of the data gathering process on the organization's smooth functioning.

They must also learn to provide feedback to the organization only when it will lead to progress, towards health or some goal.

Clinicians as well as ethnographer are not expected to pass on information from one group to the other group or from group lower in the hierarchy to the group in hierarchy without first validating the information from the group concerned. Any information which the group feels will be harmful to their

interest should not be passed on to any other group & persons.

11.0 Summary of the Clinical Perspective :

The summary of the clinical perspective can be summarised into following several points.

1. The process is client initiated.
2. The inquiry is client & problem-centred.
3. The inquiry is oriented towards pathology & health.
4. The process involvs exchange of services for fees.
5. Data comes from clients needs & perspectives.
6. Inquirty comes from clinician's theory of health.
7. Data are deep but not broad.
8. Data involve matters that must be kept confidential.
9. Data are validated through predicting respones to interventions.
10. Data are analyzed in case conferences through sharing with colleagues.
11. The clinical/legal responsibility is to avoid malpractice.
12. Training is focussed on helping skills & is supported by internship.
13. Scientific results are secondary to helping.
14. Clinical data are one valid basis for doing organizational research.
15. Clinical research is the best way to learn about what goes on in the power centres of the organization.

12.0 Conclusion :

This information must be good enough to develop awareness of the importance of clinical perspective in the field work among TTTI faculty. This skill must be developed by TTTI faculty members assigned this task of improving the technician education system. The absence of this skill has resulted in no improvement at any level of the technician education system : classroom, department institution and state level organisations. The client system is not very eager to invite TTTI mebers for help (There are, ofcourse, few exception). Ample number of seminars take place to find out what is wrong with the system but no systematic follow up action takes place to assist the client system by providing clinical help to identify the problem, diagnose it, retrieve relevant information, fabricate solution & implement these solution.

The reason is that neither TTTIs, nor MHRD have any plans to systematically introduce this idea of clinical field work by the TTTI faculty which is in fact a more refined form of extension services. The concept of extension services exist in TTTI, but is not developed to the extent that it can be operationalized through well trained clinicians backed by infra-structural network of extension centres in the states & internal staff development centre in each client system i.e. educational institutions & organizations for policy making & administration.

While the environment is changing fast and the problems are multiplying, TTTIs are getting stagenant & losing their vitality which characterized them few years back. The situation in the technical education system is bound to worsen if the timely action is not taken to strengthen TTTI's as a resource system and reinforce their roles as clinicians with supporting infra- structural newtworking through establishing TTTI Extension Centres

& staff-development cells within the polytechnics and the Directorate & the State Boards of Technical Education.

Reference :

1.0 SCHEIN E. The Clinical Perspective in Fieldwork (1987) Sage University paper series on Qualitative applications in Social Sciences, 07-001, Beverly Hills : Sage Publications.

2.0 LAWRENCE & Organisational Development (1969) : New York : Addision Wesley (Organisational Development Series).

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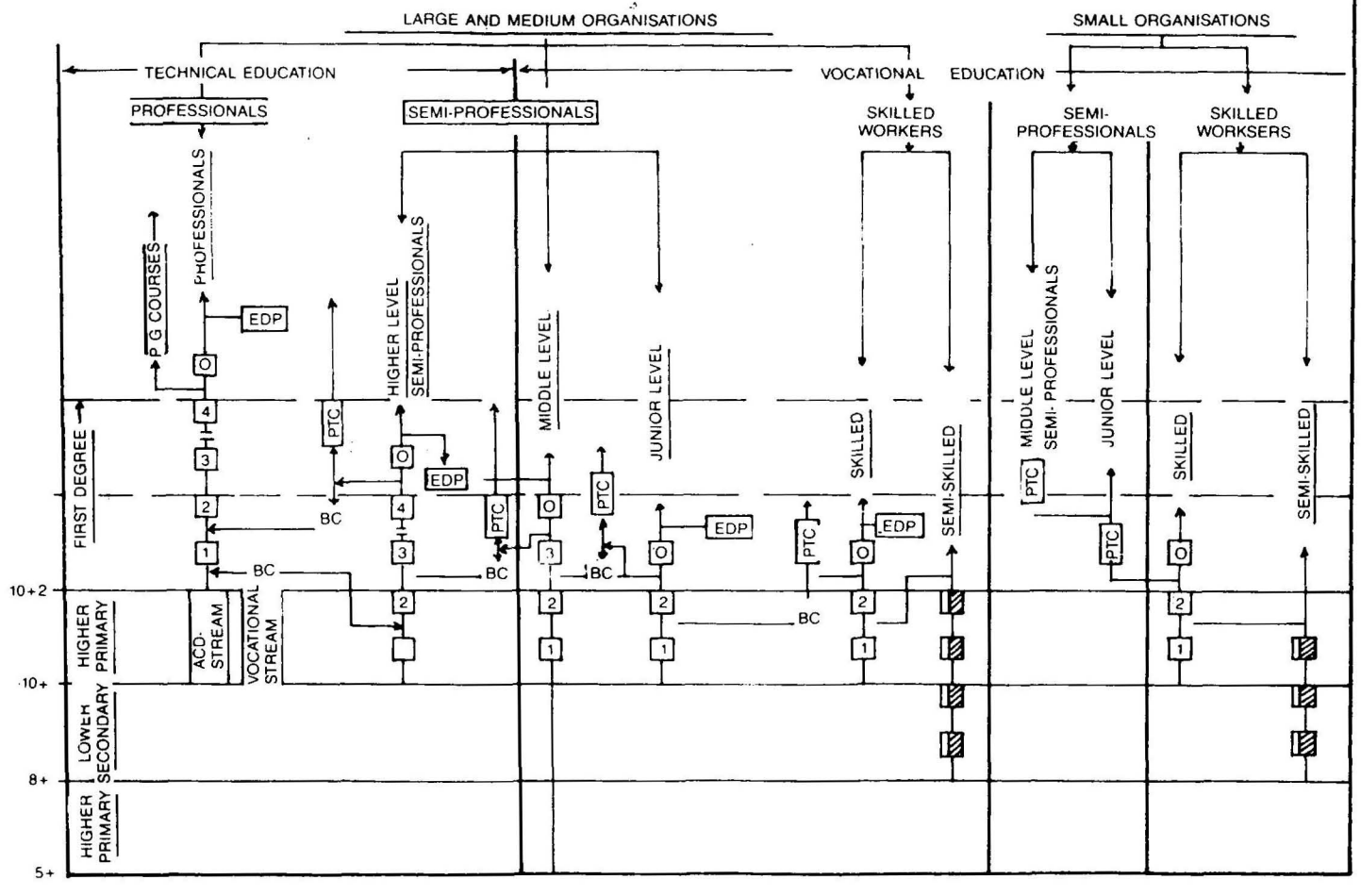
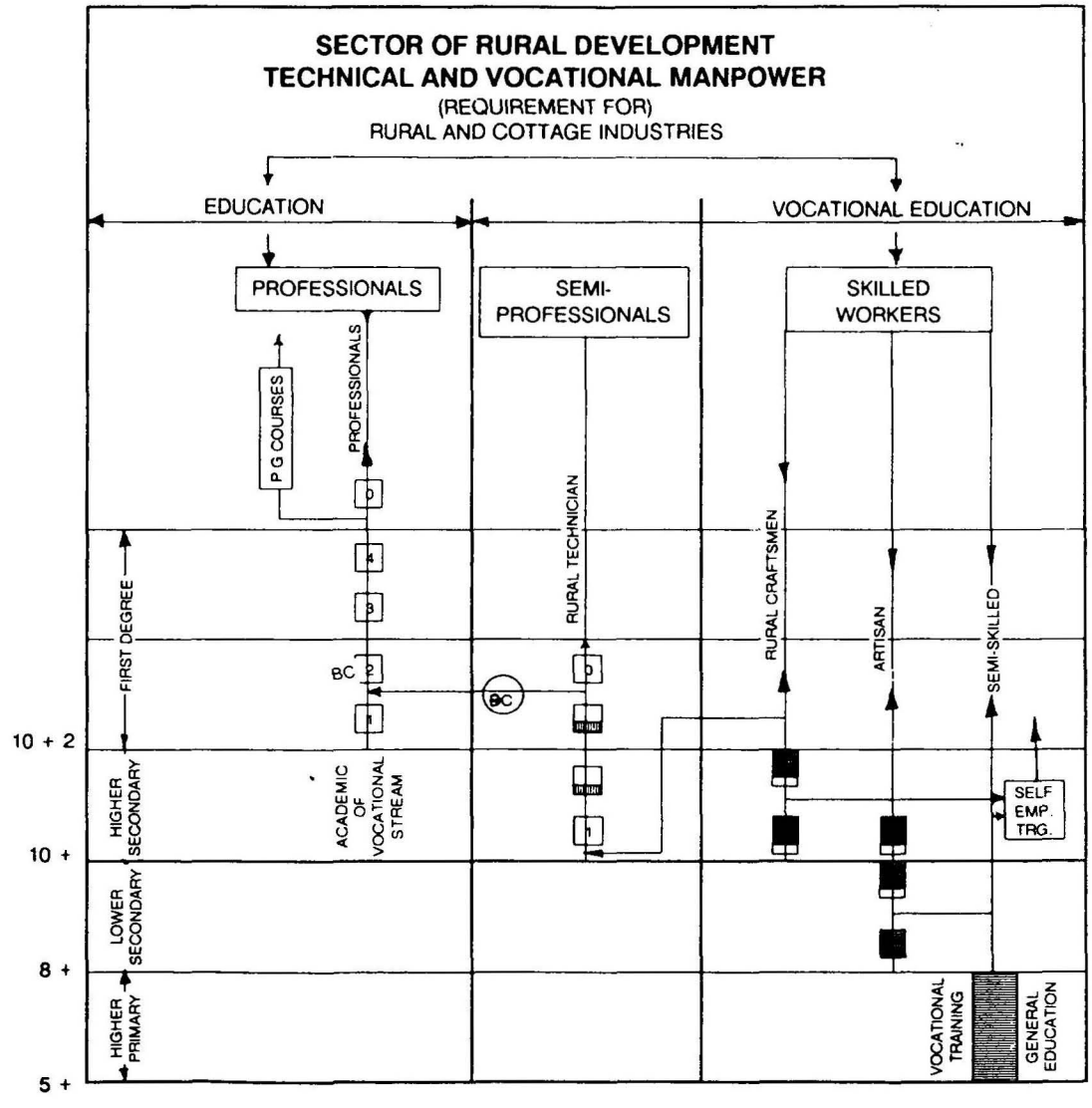
FIG. 1

SECTOR OF URBAN DEVELOPMENT
TECHNICAL AND VOCATIONAL MANPOWER REQUIRMENT

(FOR PRIMERY, SECONDARY AND TERTIARY SECTORS)



ORGANISATION OF VOCATIONAL EDUCATION



LEGEND

FIG. 2

URBAN DEVELOPMENT

1. ECONOMIC DEVELOPMENT
   - -- Primary (Agriculture & Allied Industries)
   - -- Secondary (Manufacturing)
   - -- Tertiary (Service)

2. SOCIAL DEVELOPMENT
   - -- Education
   - -- Health
   - -- Tourism
   - -- Recreation
   - -- Communication
   - -- Defence
   - -- Legal

- -- To World of Work .....
- -- Internship .....
- -- Teaching of concepts, principles, Procedures & related skills .....
- -- Entrepreneurship Development Programme ..... EDP
- -- Part-time courses ..... PTC
- -- Bridge Courses ..... BC
- -- Practical training in industry .....
- -- Skill training in the institute .....

Note The word industry in a broader sense means any organisation entrusted to given output to the society in all the three sectors of development.