

The Educational Clinic— A Means for Curriculum Change—

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"The educational clinic is a means to an end—and the end is the improvement of instruction," writes L. D. Haskew, dean of the College of Education, University of Texas. This article explores the possible uses of the educational clinic in programs of curriculum development.

THIS ARTICLE deals with the educational clinic as a means toward curriculum improvement. The distinguishing characteristic of the educational clinic is use of a live program to give a point of reference for study and deliberation.¹ Hence, this article begins by describing such a clinic situation.

One City's Problem

A Southwestern city school system found each year that approximately one-fifth of the youngsters who entered first grade came from homes in which English was seldom spoken, and that at least ten percent of the children themselves could not use English at all. What sort of school curriculum would be best for these children?

No formal attempt had been made to answer that question in this particular school system. In fact, the director of curriculum suspected that many teachers were not even aware that a problem existed. Most teachers had worked out some sort of personal adaptation, and the characteristics of the adaptations varied considerably.

On one of the system's "keep abreast" days, the curriculum director

raised the question in a discussion period with primary teachers. He invited several teachers to describe briefly what they were doing to bridge the language handicap. One was using Spanish constantly in the classroom; another was forbidding its use entirely. Fifteen different approaches were identified. No arguments about merit took place, but a lively curiosity was evidenced. A committee was appointed to lay plans for carrying this exploration further.

Utilizing the Clinic

The committee chose a clinic as the next vehicle for moving along the road toward curriculum improvement. A nearby city with similar population was approached with a request that its program for dealing with second language difficulties be offered as a "patient" for the clinic. The compliance was most enthusiastic.

A committee from the visiting city and one from the host city made preparations together. The host program was analyzed to discover its salient features. These features were described in a prospectus that went to the visitors. Plans were made for each aspect of the program to be presented so that it could be viewed at first hand. Visitors

¹ L. D. Haskew, *The Educational Clinic*, Washington, D. C.: American Council on Education, 1948.

divided themselves into teams for observing one aspect each.

On "Clinic Day" visitors and hosts really got around. One team observed the school tester administer non-verbal mental aptitude tests to entering children. Another heard the primary supervisor expound the theory upon which the host program was built, and then accompanied her to several classrooms. A third team interviewed a large number of primary teachers. A fourth observed the daily work of one first-grade teacher. Four other teams had equally challenging opportunities.

At the conclusion of the observation each team and its host discussed what had been seen. Factual questions were answered, background was filled in, and comparisons of host practices with visitor practices were brought out.

Putting the New Into Practice

Back home, the visitors met immediately to share what they had seen and thought. The curriculum director took the lead in getting several curriculum issues identified and was delighted at the keenness of perception that had been built.

Throughout the process of study and experimentation and more study that has followed, the concrete examples furnished by the clinic have been invaluable. The early tendency to imitate what was seen was followed by a critical evaluation of each proposal and much original invention.

The foregoing is not a true story. It is a composite of several experiences with the clinic approach, and is designed to illustrate in some detail one use of the clinic as a means toward curriculum improvement. Let us now

turn to a descriptive cataloging of some ways in which the educational clinic may facilitate curriculum change.

ADAPTABILITY OF THE CLINIC

The clinic approach may assist in analysis of "what is." In almost any program of curriculum development there comes a time when it is highly desirable that participants take a frank, appraising look at what is going on at the present. Just what is our program for developing meanings in arithmetic? Just exactly what are we doing to increase the skills of group participation among our students? Many educational leaders have pointed to the difficulty of getting teachers and administrators to proceed beyond the point of vague generalities in telling either what they are doing or why they are doing it.

When the host teachers in our opening illustration set out to portray their program for bridging a language handicap, they had to give serious, analytical thought to what they were doing. Just what were they stressing? What followed what? And their objectives—could they be shown as influences on their actions? It is common testimony among those who have served as hosts in an educational clinic that the experience helped them to get much clearer insight into the curriculum they were actually providing.

The clinic approach may arouse a high degree of teacher interest. Most educational clinics have drawn open expressions of enthusiasm and acclaim from participants. Talk has been started, and determination to get something rolling has been frequent. Most leaders in curriculum change yearn for

just such fire and often find it difficult to kindle.

Presumably, adult professional workers should need no extra stimulation to effort that will improve the school curriculum. Yet, inertia is all too common and is cited by many as the chief barrier to curriculum change. The evidence thus far indicates that an educational clinic may serve quite admirably as the outside force that changes inertia into momentum.

The clinic approach may touch off ideas. Curriculum change depends in large degree upon teachers having an urge to do something different, and then inventing that something different. No one knows much about the mental process we call invention, but apparently there is some connection between the observation of phenomena under conditions of high attention and the production of new ideas. Attentive observation of a steaming tea kettle is reputed to have given us the steam engine; Kilpatrick's observation of a listless class of college students gave us a new idea of the nature of learning—and that idea certainly gave us curriculum change.

"You know, while we were watching those children hold that committee meeting the other day the idea came to me that maybe we could . . ." is a very common statement from participants in an educational clinic. Somehow, the concrete example serves to give "hunches" to many people. Oftentimes these notions are not directly related to the clinic subject, but they seem to have the merit of being something that the individual feels he can do in his particular situation. Thus, the

clinic may provide a little of the essence of curriculum change.

The clinic approach may build camaraderie and a sense of common endeavor. Most efforts to bring about curriculum improvement place major reliance upon group, as contrasted with individual, enterprise. Scientific knowledge and well-disciplined procedures are undoubtedly essential in building better curricula, but that knowledge and those principles must be applied by flesh-and-blood human beings who are working together as a genuine group. Therefore, the creation of group-ness is a major strategy in any curriculum endeavor.

All of the paraphernalia and machinery of the clinic approach are designed to further friendly, intimate groupings of people. People share the same conveyance, the same little jokes, the same observation experience, the same discussion sessions, and so on. An educational clinic is no magic prescription for developing cohesiveness and common purpose but it does seem to assist in realizing these objectives.

The educational clinic adds concreteness to abstractions. The extent to which most curriculum change is made dependent upon abstractions is seldom realized. "A variety of activities" is a fine phrase, but it remains only a phrase until referents are added. All too often, the total effort of a curriculum study group may be summarized as the building of myriad little abstractions into multitudinous super-abstractions. Of course, most of us realize that the only curriculum a child has consists of his own experiences, but we

find ourselves constantly pulling away from those concrete experiences into a realm chiefly notable for the volume of polite horse-trading with phantom horses.

The educational clinic was developed as one protest against the process of abstraction. It attempts to provide a group of people with common referents, with examples of concrete experience, and with as much reality as possible. The success of such attempts undoubtedly leaves much to be desired, but testimony of participants in clinics seems to justify the claim that the

clinic procedure may be employed to avoid over-abstraction.

A DEVICE ONLY

Only a few of the possibilities in the educational clinic have been explored in this article. In true clinic fashion, the purpose has been to set off a train of thought, to provide a few examples that may suggest local adaptations and inventions that will profit curriculum development. The educational clinic is only a device, a means to an end—and the end is the improvement of instruction.

Education in a New Perspective

LIBBIE B. BOWER

The seminar described here was part of a design for in-service teacher training based on educators' interest in human relations. Libbie B. Bower, Consultant for the School Project, The Massachusetts Society for Mental Hygiene, Boston, shows how use of the group process helps to sensitize group members to change.

THE EXPERIMENT described here grew out of an interest in the field of human relations expressed by several educators while we were conferring with them on a school project, *Human Relations in the Classroom*, sponsored by The Massachusetts Society for Mental Hygiene.¹

The director of the Society, William H. Savin, anticipating this interest, had prepared a design for teacher training on three levels, one of which was the seminar described here. He had secured

as leader for the seminar a psychoanalyst trained and experienced in group therapy. This psychoanalyst had demonstrated with groups of social workers and mothers of children under psychiatric treatment, skill in creating a setting in which they had been helped to work out some of their own problems. Announcements mailed to a restricted list of prospects (the number of participants had to be limited to not more than fifteen) included the statement:

"The seminar in individual and group psychology will meet weekly for twelve two-hour sessions. After

¹ Bullis, H. Edmund and Emily E. O'Malley, *Human Relations in the Classroom*, The Delaware State Society for Mental Hygiene: Book I, 222 pp., 1947; Book II, 219 pp., 1948.

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