

## SERVICE LEARNING

by Sandra McCleaster RRT



This last decade has brought some new-think to the process of teaching and learning. Searching for new ways to structure curriculum always brings some innovative educational models to the forefront. One paradigm of interest is "Service Learning."

Service Learning is an organized approach for students to service needs in their local communities, either geographic or professional, with the format being a faculty-approved, course-related volunteer project. Teachers act as facilitators for their students in finding ways to contribute to the world around them; the students in turn learn in relation to their course work.

In 1993 the government charged higher education to show that it was preparing students for the workplace and good citizenship. Congress established the Corporation for National Service (CNS) which in turn enacted "Learn & Serve America, Higher Education". Through this initiative colleges and universities could apply for funding for the express purpose of developing programs and courses wherein students voluntarily serve their communities. The CNS also provides technical support.

Service Learning can be accomplished in different ways. It might be a stand-alone credit-bearing course or offered as part of a larger fundamentals course (probably the better option for allied health programs). At the discretion of the faculty, it could earn extra credit or serve as an alternative to a research paper or test. Whichever configuration or grading approach is used, the key lies in its relation to specific course content and the fact that it is an outreach-oriented volunteer work activity. The Service Learning

need not be mandatory and may very well just be offered as an optional element of the curriculum.

In contrast to pure "volunteerism" Service Learning has as its focus the learning experience of the provider. Part and parcel of each experience is a final summary and personal critique. This post-service reflection is an integral part of the Service Learning concept, recognizing that, even though the recipients benefit from the project, the *primary* outcome is the students' intellectual growth.

Proponents of Service Learning hail its benefits. Measuring the actual outcomes may defy formal attempts at assessment, but nonetheless, the benefits certainly seem intuitive.

First of all, Service Learning promotes "active" learning. One of the basic tenets of education reads that real learning connotes use. Students must talk about what they are learning, relate it to a current experience, apply it to something. Service Learning accomplishes this because students are actually doing something with what they've derived from the classroom. In a well thought out Service Learning project, theory and practice are integrated in the setting of the "real world".

Service learning also helps to build leadership skills that will give graduates an edge in a competitive job market. An experience in collaborative work and team-building will surely serve students well as contemporary health care providers. Involvement in the professional community often places a student in the right place at the right time. In short, Service Learning can bolster a graduate's resume and open the door to jobs. Service Learning is also a welcome departure from the lecture and lab format of teaching. Students like having a break from the formal classroom. For most people, hands-on experience and interpersonal communication will trump even the most meticulously prepared lecture.

Service Learning is attracting attention across many academic disciplines, but it's a concept that I feel lends itself particularly well to the world of allied health.

Respiratory care, nursing and sleep medicine provide fertile ground for the implementation of service learning projects. Health screenings, patient-consumer education, development of instructional videos or slide presentations, are all great volunteer projects. Specialty clinical areas (PFT, sleep labs, out-patient asthma or CF clinics, etc. are all appropriate sites to which student health care providers can bring service and enthusiasm.

Yes, Service Learning requires a commitment from faculty, especially at the outset. Setting up the program may take a little bit of heavy lifting. Ground rules need to be established and put into place. Securing professional support across the program's community of interest is essential. Faculty must be willing to act as advisors and facilitators. Students can and certainly should seek out their own service learning opportunities and allied health faculty often have the contacts and networks to help make the connections. Plus, faculty will need to develop mechanisms for evaluation of students' experiences. This will all take some extra effort on the part of allied health educators for sure, but I would hope it be viewed as a professional obligation. Like all preparation for teaching, the first time around is the toughest in terms of personal

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A recent magazine survey indicated that courtesy has diminished in public places in the United States. People interviewed said they thought that we are no longer as polite as we used to be and this has contributed to the decline of "the quality of life."

Well, the quality of my life is just fine. I don't trust surveys and I'm not sure that we aren't as polite as ever. No way to tell, of course, but I still see a lot of people being courteous. Men often hold the door open for a woman. (This ought to make women mad, not pleased, but that's another matter.) In my office, people in the hallway or at the elevator in the morning usually say "Good morning" as though they meant it. They're polite and it makes the day better.

There may be something false about manners that puts us off being polite. Phrases like, "How do you do?" or "Pleased to meet you" don't ring true. They're devoid of meaning or sentiment and some people don't use them. I don't.

Even though I think we're as polite as ever, we may have diminished the importance of some good words like "please" and "thank you" by using them too often. Sometimes they're just fillers in a conversation. "Have a nice day" doesn't really mean much. No one gives a serious answer to "How are you?" There isn't time in the day to tell everyone who asks how you are.

Computers have contributed to the weakening of words like "please" and "thank you." When I start my computer, it says, "please wait" or "thank you" when it's proceeding with some function that takes time. My old typewriter had the good taste not to say anything.

We get artificially polite recorded messages on the telephone. "We're sorry we are unable to come to the phone right now." They're probably out somewhere having a good time. It's a dumb message. The real message is something like: "Not here. Call back later."

We got off on the wrong foot years ago when some early-day Miss Manners decided we should start all our letters, "Dear Sir,"

"Dear Mr. Rooney" or "Dear Andy." I get 20 letters a day from people who call me "dear" and I'm not dear to any of them. I don't know them and they don't know me, so please knock it off with the "Dear."

I got a letter yesterday from the New York State DMV telling me I had to renew the registration for my car. The letter started with, "Dear Mr. Rooney." I'm just not that close to anyone in the DMV.

It would be better if we were more honest than polite about everything but that isn't going to happen. It would mean that we'd all have to tell the truth all the time. The truth hurts so often that we avoid it. We're polite.

Courtesy is sometimes artificial. We lie in order not to hurt someone's feelings by telling the truth. We don't say, "Boy, you got a bad haircut" to someone who just came from the barber, but it would be a better world if we were all less diplomatic and more direct. If we regularly said what we really think instead of what we think will sound good, people would get used to it and adjust their reaction to the facts and not to a statement we made that they know is not the whole truth.

One of my grandchildren, who does not read this column, sent me something he'd written for a class that I thought was poor. What do I do? I was pleased that he cared enough about what I thought to send the piece to me and I wanted to like it but I did not. What do I say? I lie. In bed that night, I got wondering whether I said the right thing to my grandson. Should I have been honest and direct and told him his writing was poor, or should I have encouraged him by saying it was good when it wasn't?

I hope you like this column. You readers are wonderful.

### *Coccidioidomycosis* Continued from page 58

#### *Treatment & Prognosis*

Most patients infected with *Coccidioides* require no antifungal medication. Patients with pulmonary nodules and cavities usually require no medication, but must be monitored over time. When indicated, ketoconazole, itraconazole, or fluconazole are prescribed for oral administration. Amphotericin B is often used in the initial treatment of life-threatening coccidioidomycosis. Surgical resection is generally reserved for patients who exhibit severe hemoptysis, bronchopleural fistula, or who fail to respond favorably to antifungal medications. Coccidioidomycosis appears to be a reemerging as evidenced by an increase in the number of cases during the past decade. Major outbreaks have emerged in southern California in 1977 and late 1991 through 1994. A new resurgence is indicated by an increase in coccidioidomycosis during the past year in Arizona.

Most coccidioidal infections are self-limiting, and resolve either spontaneously or with treatment with antifungal drugs in a few months. On the other hand, people who have weak cell-mediated immunity and high IgG levels have a bleak prognosis. Relapse is common among patients who have disseminated coccidioidomycosis. Public education in endemic areas is important for early diagnosis of *Coccidioides* infection. Residents, especially those in high-risk groups, within endemic areas, and people traveling through these regions, should be informed of exposure risks, and encouraged to seek medical treatment if respiratory symptoms appear.

### *Safety Learning* Continued from page 44

investment and work. But then moving forward, well-planned Service Learning activities can easily take the place of canned lectures, a lab activity and a test or two. That alone will recoup some precious time and bring an extra dimension to the program.

The real challenge for both the teachers and the service sites is to assure the quality of the service learning opportunities. Obviously not all service learning opportunities will be created equal. It's not just busy work. The ultimate success of the endeavor will really depend upon the *quality* of experiences available for students. And it's the quality that will make all the difference in outcomes. To be credible, real learning must occur with real service being provided. The service experience needs to be closely connected to course content. A little training and some supervision should be available. A minimum number of hours needs to be arranged with schedules stated in advance.

At the same time, we can expect that the service sites will be grateful for the contributions of students who are providing some service or benefit that their organizations would otherwise have probably done without.

Something notable about Service Learning is the acceptance it seems to be enjoying among both students and educators. The movement has become quite visible on the nation's college campuses, seeing substantial growth since its inception.

Meeting the needs of a changing student demographic and workplace present some formidable challenges for allied health programs. Service Learning serves as one valuable possibility to realizing the needs of both students and communities at large.