
EDITORIAL

Practice Education and Practice Placements: Universal Problems

John H.V. Gilbert

Email: johnhvg@mail.ubc.ca

Abstract

It is now recognized that effective interprofessional education (IPE) requires active engagement of students from different professions using interactive learning methodologies to develop health professional students' knowledge, skills, attitudes, perceptions and behaviors. IPE is a complex adult learning (andragogy) approach that is most effective when integrated throughout a program of study moving from simple to more complex learning activities that bridge from post-secondary to practice education settings. Educational accreditation standards being developed to stimulate the advancement of IPE will have an impact on policies in both academic and clinical settings.

"For the things we have to learn before we can do them, we learn by doing them."

Aristotle, *Nicomachean Ethics* (350 B.C.E)

Editorial

Learning to become a competent health professional has always been a two part process – that which focuses on “classroom” teaching, and that which engages students in an apprenticeship with qualified professionals in real-world settings. Universities, colleges and institutes depend upon practice settings for the apprenticeship education of their health professional students. Practice education (PE) settings require competent health care professionals to deliver quality care to patients. Until recently, the delivery of health professions education has been almost entirely discipline based, with each discipline educating their own students in isolation – whether on campus or in the community. There is now increasing emphasis on all health care professions to learn how to be competent collaborators. This emerging shift in education has led to a new interest in different approaches to the delivery of health professions education which embraces more opportunities for interactions amongst and between learners across disciplines. PE settings are being recognized as ideal environments in which students can witness and practice how to work interprofessionally with others in healthcare teams, that is, to learn about, with and from each other, for the purpose of collaboration to improve quality of care (WHO 2010).

It is now recognized that effective interprofessional education (IPE) requires active engagement of students from different professions using interactive learning methodologies to develop health professional students' knowledge, skills, attitudes, perceptions and behaviors. IPE is a complex adult learning (andragogy) approach that is

most effective when integrated throughout a program of study moving from simple to more complex learning activities that bridge from post-secondary to practice education settings. Educational accreditation standards being developed to stimulate the advancement of IPE will have an impact on policies in both academic and clinical settings (see <http://www.cihc.ca/aiphe/about>).

PE is now understood to be that portion of a health professional program of studies that is devoted to applying the principles of a profession to professional practice, in the workplace. PE is organized around programs provided by communities in a variety of formats e.g. primary care, acute care, and chronic disease management. PE comprises both the placement of students in such agencies, and the education provided to those students by qualified health practitioners.

The term PE is used for two purposes: first to encompass a variety of terminologies used by health and human service/social care disciplines to describe supervised pre-licensure learning experiences such as the most common 'clinical practice' (used by Nursing and other disciplines) and 'field experience' (used by Social Work); and second to indicate that supervised learning in a practice environment is part of an educational continuum that extends from on-campus classrooms to practice setting that range from acute care and through to the larger community.

It is now recognized that a number of terms may be used to describe practice educators. For the sake of simplicity, and in conformity with the larger practice, the term Preceptor is used to signify those professionals in health and human service/social care agencies who are charged with the legal responsibility for supervising all aspects of PE.

The education of health professional students relies upon practice settings for the delivery of a significant part of the education and training required for graduation and licensure. The role of practice settings in supporting this educational mandate, however, is often not reflected in a country's post-secondary system/health system policies and procedures. Support for health and human services professional education rests in the budgets of organizations with jurisdiction over post secondary education. Yet much of the practice education supported in acute, tertiary and other settings is provided mainly by organizations with jurisdiction over the provision of health services.

It is clear that the education of health and human services professionals is undertaken in an exceedingly complex and constantly changing environment. No matter which jurisdiction is asked in the health and human service/social care sector, it is almost universally agreed that it is increasingly difficult to provide students with the practice opportunities that are built into educational programs through accreditation expectations. Fiscal constraints on governments in both health and education worldwide, have resulted in changes to programs and downsizing of staffing which in turn has decreased the flexibility of health and human service/social care organizations to effectively support education for practice. Meanwhile, major technological changes in both health and education sectors are dramatically influencing the education process and contributing to growing pressures relating to the development of the health workforce.

From a health system perspective, significant changes are underway with program management, regionalization of services (and its analogs worldwide) and a notable shift in care of chronic diseases from institutions to the community. Recovering patients who have been acutely ill are transferred to the community at an earlier stage. The most acutely ill form the basis of much initial teaching and learning. This high acuity of patients increases the competency requirements of staff, at a time when continuing education budgets and human resources supports are constrained. At the same time, staffing patterns have changed with fewer supervisory/managerial positions, and more part-time, and often less experienced staff. At a health organizational level, these factors combine to decrease the

ability and flexibility to effectively support students in the clinical practice education (PE) settings both for their professional training, and for interprofessional learning. It has become increasingly difficult to provide the breadth of practice education placements that are considered sufficient and appropriate to meet competency requirements. Employers in the health services sector often complain of students graduating as “practice ready” but not “job ready”.

From an educational perspective, changes in health care are requiring new skill sets and a different type of graduate, regardless of discipline. Curricular changes to meet required new skills influence PE; for example, through the need for diverse learning settings at earlier stages of a professional education program. These changes create increasing challenges in the coordination of, and communication about, learning experiences provided under the rubric of PE. There are a number of key issues that impinge on providing meaningful learning for the approximately 40% of time that students spend in their pre-licensure training, learning the scopes of practice that their profession will require them of them, on graduation.

The literature relating to PE highlights a number of themes including the benefits for students, organizations and clinical supervisors or preceptors; supports required for effective PE and the respective responsibilities of health and educational organizations.

The benefits in all parts of the system have been known for many years. For students they include the exposure to everyday practice, the ability to apply theory to practice, increased clinical competence and the strengthening of skills and self-confidence (Letizia & Jennrich 1998). The benefits perceived by preceptors include their personal satisfaction from sharing knowledge and expertise, stimulation of their personal growth, honour and recognition for their work, an abiding satisfaction from watching the preceptee/student grow, and the opportunity to teach and improve their own teaching skills (Dibert & Goldenberg 1995, Ferguson 1996). The benefits for organizations are clear and include the new ideas and enthusiasm that students bring to an organization, the ways in which student teaching enhances staff confidence, expertise, and recruitment and the opportunities afforded to staff to undertake special projects or research with students.

Despite these ‘upsides’ there are a number of ‘downside’ issues of PE; these include, but are not limited to the fact that selection of preceptors is often made on the basis of which individuals in an agency are available to supervise a student or students, rather than by demonstrated adult learning skills: for example, clinical expertise, leadership, communication, clear decision-making, interest in professional growth, sound knowledge base, organizational abilities, effective teaching skills and commitment to the role of preceptor (Letizia & Jennrich 1998). Preceptors are frequently given little or no preparation to take on the many roles required of them, including the complexities of appropriate and informed evaluation of their own teaching, and what students have learned (Letizia & Jennrich 1998). Many preceptors experience difficulties understanding the expectations of an academic program or her/his role as an educator, particularly that of evaluator of student competencies. It has been frequently observed that clinical/practice expertise does not necessarily translate into preceptor skill (Keith 1993). Because of the different nature of classroom learning versus practice learning, there are frequently discrepancies between the goals of health care and educational institutions (Letizia & Jennrich 1998), and because of the intense nature of practice, burnout of preceptors is not recognized or clearly understood on the academic side, particularly when practice workloads are heavy and there is little or no recognition of the important role played by preceptors in pre-licensure education.

Clearly, the importance of coherently and congruently planned collaboration, and clear and frequent communication between and among educational programs, receptor agencies and preceptors cannot be over emphasized. As agencies move closer to interprofessional

learning and practice, the roles of professional education and interprofessional education will need to be clearly placed in an appropriate context. It is preceptor burnout that has attracted the most concern and a number of possible mechanisms have been suggested to recognize and support the important role played by preceptors.

There are a number of approaches that could not only address the problem of preceptor burnout but which at the same time could facilitate and sustain appropriate PE contexts.

First, and at the highest level, there must be commitment of all stakeholders to collaboration, and to the shared goal of facilitating the highest level of PE to ensure a health workforce which is prepared for interprofessional collaborative practice and care. It must be recognized by health and educational organizations that there is a collective responsibility and benefit to the provision of high quality PE. Health care organizations need competent and qualified staff to meet human resources and program/service plans based on the needs of their communities. Educational organizations have the responsibility to ensure the provision of competent graduate. Efforts to ensure 'practice ready' and 'job ready' health professionals are of benefit to all - the students/graduates, receiving health care organizations, educational institutions and ultimately the communities and clients/patients served.

Second, there must be recognition and support for preceptors, and established mechanisms to develop supportive relationships and clear lines of communication. The literature identifies a number of opportunities for recognizing additional workload responsibilities for preceptors. These include, but are not limited to, the following: the use of financial rewards; credit towards an educational degree; reduction in clinical assignment during preceptorship; demonstration of appreciation through written letters and/or celebratory events; formal recognition mechanisms; cross-appointment to the educational institution; development of clear role expectations; guidance and support in developing learning possibilities; appropriate and useful feedback on teaching; facilitation of research opportunities and consultation with faculty; greater access to email and internet. In particular, ongoing continuing professional development (CPD) for preceptors is important, including: formal training in the principals and methods of evaluation; new learning related to both disciplinary areas of practice and emerging interprofessional teaching methods; access to reduced fees for CPD; agreement on leave for; and allowing a period of adaptation (e.g. 3 months) for staff introduced to a new area/unit, before being expected to preceptor/support student.

Third, and immensely important in developing successful PE programs, preceptors must have access to academic faculty support in order that they have up to date information on changes within academic departments, and knowledge and understanding of the evaluation of student performance, outside of practice education settings.

Finally, given the many changes occurring in the health and post-secondary education sectors, there is growing need for partnership, coordination and communications between the organizations. This includes better communication about curriculum change and development; a shared understanding of the academic and professional objectives of PE; and a shared knowledge of how to manage conflict in PE settings. PE needs innovative models for interprofessional learning programs, based on the health of the population, which would provide valuable insights into how professional knowledge and skills might be best employed to address health workforce shortages. Currently there is no universal database or inventory of PE placements (but see <http://www.hspscanada.net>) that is able to identify linkages between health care and educational institutions, numbers and types of students placed and a large number of related demographic items of interest. Developing such data would provide an opportunity to better assess current PE and evaluate

opportunities for improving the coordination and appropriateness of these placements for interprofessional learning, both within, and across, countries.

Nominandum est rutrum rutrum – it's time to call a spade a spade. In many senses, PE represents what Rittel & Webber (1973) have called a “wicked problem.” Wicked problems are “difficult or impossible to solve. Their solutions depend on incomplete, contradictory and changing requirements that are often difficult to recognize. And they are confounded by complex interdependencies between actors and agents”. If ever there was a wicked problem, innovation in PE is surely one. What could be more complex than relationships between governments, postsecondary institutions, the healthcare industry – and the professions? As interprofessional education advances and new expectations are placed on practice education, it will require far more attention than it has thus far been paid.

References

- Dibert, C. and Goldenberg, D. (1995) Preceptors' perceptions of benefits, rewards, supports and commitment to the preceptor role. *Journal of Advanced Nursing* **21**, 1144–1151.
- Ferguson, L.M. (1996) Preceptors' needs for faculty support. *Journal of Nursing Staff Development* **12** (2), 73–80.
- Keith, P. (1993) An evaluation of the preceptor method of instruction in an obstetrical nursing specialty. M.A. Degree, Simon Fraser University. URL: <http://summit.sfu.ca/item/5769>.
- Letizia, M. and Jennrich, J. (1998) A review of preceptorship in undergraduate nursing education: implications for staff development. *J. Continuing Educ. Nurs.* **29**, 211–216.
- Rittel, H.W.J. and Webber, M.M. (1973) Dilemmas in a General Theory of Planning. *Policy Sciences* **4**, 155–169.
- WHO (2010) Framework for Action on Interprofessional Education & Collaborative Practice. Health Professions Networks, Nursing & Midwifery, Human resources for Health. WHO/HRH/HPN/10.3. URL: http://www.who.int/hrh/nursing_midwifery/en/.