

SHOULD MIDWIFERY EDUCATORS BE REQUIRED TO MAINTAIN CLINICAL PRACTICE?

DEVRAIT-ON EXIGER QUE LES PROFESSEURES SAGES-FEMMES MAINTIENNENT UNE PRATIQUE CLINIQUE?

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ABSTRACT

This paper presents the results of a literature search on the role of clinical practice for midwifery educators. University-based midwifery education in Canada has a short history, with Ontario first admitting students in 1993, Quebec in 1999 and British Columbia in 2002. Although the move to formal, accredited programs has increased the rigour and uniformity of education, it also poses challenges to learning. One such challenge is overcoming the theory-practice gap, a challenge shared by other health disciplines. Studies from the United States, Australia, New Zealand and the United Kingdom suggest that college and university-based midwifery and nurse educators are isolated from clinical practice and decision-making. Most lecturers surveyed in these studies viewed clinical teaching as fulfilling a requirement for clinical practice. Few were actually in clinical practice. This precipitated the perception by staff and clinical managers that midwifery and nursing educators were not clinically credible. Studies uniformly conclude that organizational structures must be created to support the practice role of health professions' educators within the educator's academic and practice positions. The concerns identified in the international literature inform issues currently faced by midwifery education programs in Canada.

KEYWORDS

midwifery educators, theory-practice gap, clinical competence, clinical credibility

THIS ARTICLE HAS BEEN PEER-REVIEWED

RÉSUMÉ

Ce travail présente les résultats d'une recherche sur la littérature portant sur le rôle de la pratique clinique pour les professeures sages-femmes. Au Canada, l'histoire de la formation universitaire en pratique sage-femme est toute récente. En 1993 l'Ontario fut la première province à admettre des étudiantes, suivie par le Québec en 1999 et la Colombie Britannique en 2002. Quoique la transition vers des programmes formels et accrédités augmente la rigueur et l'uniformité de la formation, cela présente aussi des défis en matière d'enseignement. Un des obstacles à surmonter est l'écart entre la théorie et la pratique, un défi qui est partagé par d'autres disciplines du domaine de la santé. Des études des États-Unis, de l'Australie, de la Nouvelle-Zélande et du Royaume-Uni, laissent entendre que les professeures en pratique sage-femme et en technique infirmière qui enseignent en milieu collégial et universitaire sont isolées de la pratique clinique et de la prise de décision. La plupart des enseignantes consultées dans ces études considéraient que l'enseignement clinique satisfaisait une exigence de la pratique clinique. En fait, peu d'entre elles travaillaient en pratique clinique. Ceci a eu pour conséquence que le personnel et les gestionnaires cliniques présumaient que les enseignantes en pratique sage-femme et en technique infirmière manquaient de crédibilité au niveau clinique. Les études sont toutes venues à la conclusion que des structures organisationnelles doivent être mises en place pour appuyer les enseignantes du domaine de la santé en ce qui a trait à leurs fonctions au niveau pratique à

l'intérieur de leurs positions pédagogique et clinique. Les préoccupations identifiées dans la littérature internationale contribuent à l'élaboration des questions auxquelles les programmes de formation en pratique sage-femme au Canada doivent actuellement faire face.

MOTS CLÉS

professeure sage-femme, l'écart entre la théorie et la pratique, compétence clinique, crédibilité clinique

CET ARTICLE FUT RÉVISÉ PAR SES PAIRS

INTRODUCTION

This paper presents the results of a literature search on the role of clinical practice in maintaining clinical competence for midwifery educators. The integration of midwifery into the health care system in jurisdictions across Canada has precipitated the need for education programs to ensure health human resource needs are met. Therefore, discussion on the issue of whether midwifery educators should be required to maintain clinical practice in all provinces is both timely and relevant, especially if we value consistency in standards for educational competencies. To investigate these issues we can draw on the international experiences of midwifery educators.

BACKGROUND

The Midwifery Education Programme of Ontario (MEP) was the first to be established in Canada in 1993. It was founded on two core beliefs:

1. A significant portion of midwifery education would take place in the clinical setting.
2. Midwifery educators must retain active practice requirements and be registered with the College of Midwives of Ontario (CMO).

Prior to regulation most aspiring midwives were trained through an apprenticeship model. Within the move to formalized education, benefits of an apprenticeship model were recognized and retained through a focus on clinical education. It was decided that 50% of midwifery education would take place in the clinical setting. Also, in order to ensure that the philosophy and model of Ontario midwifery care would provide the context for clinical teaching, it was considered essential that midwifery students receive the majority of their clinical education from midwives. Because midwifery is still a small profession in Ontario, most community midwives are clinical preceptors.

CLINICAL CURRENCY IN MIDWIFERY EDUCATORS

Clinical teaching is augmented with theoretical knowledge through weekly three-hour long tutorials that are taught by midwifery faculty, all of whom must be registered and maintain active practice requirements with the CMO. Based on submissions by the Association of Ontario Midwives (AOM) this requirement was recommended in the Report of the Curriculum Design Committee on the Development of Midwifery Education.^{1,2} Discussions within the AOM confirmed the belief that, as educators, midwives must live their role as care providers and maintain a connection to the real world of midwifery practice. It was believed that clinical credibility was established through first-hand knowledge of contemporary practice. By remaining aware of the realities and demands of clinical practice, and by doing what they taught, midwifery educators would have relevance and credibility with students, colleagues and themselves. This led to active practice requirements of the CMO being part of the hiring criteria established for midwifery faculty, applied with flexibility. It was considered an essential element of the education program to ensure clinical and academic competence were modeled to students from a perspective that conveyed philosophical congruence with Ontario's midwifery model of care.

Midwives' academic positions range from 20% to 80%, allowing variation in lecturers' amount of clinical practice. In addition to their academic and clinical roles, midwifery educators frequently do double duty as clinical preceptors to students placed in their practices.

REVISITING THE CRITERIA FOR CLINICAL CURRENCY

Ten years after the beginning of the Ontario education program it is appropriate to reflect on the value of

active practice for midwifery educators at both provincial and national levels. As we move towards the national regulation of midwives, it is important that efforts are made to achieve consistency in quality and standards of educational programs inter-jurisdictionally. The discussion of expectations of clinical practice by midwifery faculty is an issue fundamental to the national development of the Canadian midwifery profession and also informs other jurisdictions who look at the Ontario program as an efficacious pedagogical model.

The Midwifery Education Programme of Ontario has been judged in three external reviews to be one of the finest, if not the finest, in the world.³⁻⁵ Likewise, there is much to be learned from midwifery educational practices in other jurisdictions and from other health professions. For example, medicine and dentistry have a long-standing tradition that requires a clinical commitment, as well as the education commitment, from lecturers. This is not the case for midwifery; however, where most midwives withdraw from clinical roles once an academic role is obtained.⁶⁻¹⁰ The following literature review reports on the importance of clinical practice to education.

LITERATURE REVIEW

A review of the research literature for both midwifery and related health professions was conducted using Medline, PubMed, Google and ProQuest. Search terms used were: midwifery educators, clinical practice, faculty practice, theory-practice gap. This search produced a large number of articles on health care educators' role in clinical practice. Articles are limited to those published in English and are from the United Kingdom, the United States, New Zealand and Australia. A few articles were found discussing the issue from the midwifery profession's perspective. Many articles address the issue from the perspective of the nursing profession and are relevant to the discussion.

It is clear that the debate about a theory-practice gap has been ongoing in midwifery and nursing.⁶⁻¹⁸ "Theory-practice" is used in the literature to refer to the differences between what students are taught in the classroom and what they experience in practice settings and is linked to the move of education from hospital to university. The "gap" refers to both the

preparation of students to assume clinical responsibilities and the educator's clinical credibility and knowledge about contemporary practice.¹⁹⁻²⁶

The terms "clinical competence" and "clinical credibility" are often used interchangeably by researchers and respondents in the studies reviewed. Clinical credibility is generally considered an assessment of the individual's knowledge in the larger clinical context. It is related to the perceptions that others have of the individual. Clinical competence most commonly refers to the ability to perform clinical functions and deliver direct care. Both terms are closely associated, as credibility is seen as a development of competence. There was no consensus in the literature on criteria used for defining either term.

The literature reviewed from the United Kingdom, United States, New Zealand and Australia expressed concern over the theory-practice gap in midwifery and nursing education and found that midwifery and nurse educators often lack up-to-date clinical knowledge and clinical credibility.²⁶⁻²⁸ With the move to post-secondary educational institutions, it is reported that midwifery and nurse educators have felt an urgent, sustained need to establish their academic credibility. Due to time and energy constraints, this is often to the detriment of clinical practice.^{8,20,29,30}

DEFINING THE EDUCATOR'S ROLE IN CLINICAL PRACTICE

There was consensus in the literature reviews that midwifery and nurse educators must maintain current knowledge of clinical practice; however, participants interpreted this in a variety of ways. Most of those surveyed viewed clinical teaching -- that is, being present in a clinical setting at intervals to provide instruction to students -- as fulfilling a requirement for clinical practice.^{14,28,32-34} However, even the definition of clinical teaching was ambiguous. Being a "link teacher" with responsibility for assessing students and supporting clinical supervisors or visiting clinical areas as liaison between students and staff were considered clinical teaching.

The level of responsibility for teaching of clinical skills was also debated. Some educators considered their responsibility to be only to impart theoretical



knowledge. Many felt that it was the staff in the clinical areas (e.g., preceptors) that were the most appropriate people to impart clinical skills and that the educator's role of being the liaison between student and staff in a clinical area was sufficient. Other educators felt that they could maintain clinical credibility through theoretical updating by perusal of professional journals, meeting clinical colleagues, attending conferences and participating in research, rather than being able to perform as an expert practitioner.^{8,25,28,30,33} Because some countries have not previously required ongoing proof of competency from midwives once registered, this has not been a pressing issue for midwifery educators. Increasingly, proof of competency is becoming an academic requirement and midwifery lecturers will also need to demonstrate their competence to practice in the future.^{12,35-37}

Of those educators who felt that providing direct care was required to truly fulfill a clinical role and maintain competence and confidence, most considered it to be optional and commonly felt unable to do so because of lack of time and high workload. Very few were actually in clinical practice. Some educators suggested that some midwives moved into an academic role as a means of escaping from the rigours of clinical practice.^{30,32-34} Nonetheless, there was an underlying acknowledgement about the importance of clinical practice and a discomfort expressed when individuals were not engaged in such practice.

LOSS OF CLINICAL SKILLS

Many educators expressed concerns related to the maintenance of clinical skills. These included loss of clinical confidence, loss of credibility with other clinicians and loss of their professional identity. The level of anxiety engendered by these concerns was considerable and it was expressed that the longer educators are absent from clinical practice the greater the conceptual obstacles are to returning.^{28,30,33} Those educators who attempted to include clinical care delivery within their role were often met with a significant degree of resistance from superiors, educational colleagues and clinical practitioners. Some were concerned that the educator was there to assess and spy on their performance. Some considered that educators were no longer a midwife or nurse.^{21,27} Surveys of staff and clinical managers

reported that midwifery and nursing teachers were not seen as clinically credible.^{26,27,30}

BENEFITS OF THE CLINICAL PRACTICE ROLE

One model of how educators can incorporate clinical practice into their academic positions is the creation of the lecturer-practitioner role, or "faculty practice." The current Ontario midwifery faculty structure has incorporated this into their educational model. However, because there has been no management structure created within which this role may function, actualizing the role depends on how individuals define the role within their specific settings.^{8,10,29,38,39} Generally, the lecturer-practitioner holds two appointments, one academic and one clinical, and reports to two authorities and alternates practice and teaching.

Benefits of this approach include the educator's ability to maintain clinical credibility and thus serve as a role model. The connection to the reality of the practice environment ensures the educator's currency and informs the teaching of theory. The dual role is believed to foster reflective practice and promote clinically-based research.

Lecturer-practitioners believe there is an important opportunity to influence clinical practice and that, when established within creative management structures, both roles can be supported and given credibility. Those with lecturer-practitioner appointments argue that both roles must be clearly defined and that agreement on the overall structure by both educational and practice agencies is essential and expectations of both organizations must be realistic.^{8,10,29,38-40}

CHALLENGES OF THE CLINICAL PRACTICE ROLE

Those educators who believe that clinical currency is necessary also believe that the practice component of the educator's role is undervalued by the educational institutions. Many problems are identified that make it difficult for educators to actively practice in a clinical role. Obtaining time for clinical practice is a major challenge when priority is placed on classroom instruction and research within a university environment. For example, recognition of clinical competence and clinical practice is not included in the

promotion and tenure process of universities.^{8,10,29,32,33,40} Overall, educational institutions are seen to fall far short of recognizing the importance of the practice role.

Researchers report there are no uniform, university-based guidelines regarding recognizing the dual nature of the educator's position and attendant expectations of their roles. The concern is reiterated that college and university-based teachers are mostly isolated from clinical practice and decision-making. It is considered essential that organizational structures be created for both educational and practice sites instead of the current ad hoc approach that exceeds the educators capacity.^{6,8-10,20,29,30,33,40} Although the lecturer-practitioner role is seen as the model with the most promise for the future, there is concern that without the appropriate support structures, workload and personal and emotional demands will defeat the enthusiasm and job satisfaction these educators initially experience.

In a comprehensive report of a national survey of midwifery and nurse lecturers in the practice setting, Day et al explored the factors promoting or inhibiting the practice role and identified national variations in faculty practice. Ways in which university-based programs affect academic and clinical credibility and the impact on competence and best practice were investigated. In this study, prepared for the English National Board for Nursing, Midwifery and Health Visiting, Day et al reports: "This research provides strong evidence that there is little to no strategic management of the practice role of lecturers."⁸

Regulatory bodies, government agencies and concerned professionals increasingly recommend that future educators must be clinically credible in the area of practice that they teach.^{6,11,12,35-37} Day et al note that, although a percentage of time in the clinical setting is mandated by the regulatory body, there is seldom a mechanism in place to audit the educator's clinical activity and lecturers have an unacceptable degree of latitude in fulfilling the practice requirement. The report further notes that reductions in teaching staff have led to increased academic workload for those remaining and caused further difficulty for those educators trying to participate in a clinical role.⁸

The literature identifies that educators themselves

must be committed to the development of clinical practice as an integral part of the academic's role. Researchers assert that it is essential for educators to be agents for change and act to ensure the formal integration of the clinical role in educational policy. It is unclear how committed educators are to this process. It is recognized that the integrity of the teaching role depends on a formal acknowledgement of the value of clinical practice.^{20,30,33} Day et al report that respondents believe university teaching and practice-based teaching will soon become outdated unless educators' professional development in practice occurs.⁸

In 1986, Algate presented a compelling argument for the re-integration of the practice and teaching of nursing. While acknowledging that the need for the development of a scientific and theoretical basis for practice requires the establishment of professional disciplines in academic settings, she asserts that those disciplines cannot abdicate their responsibility to be accountable to the needs of society and the practical aims of the profession. Algate maintains that if academics remain separated from the real world of practice, their sense of professional direction will diminish and their questions will become increasingly "irrelevant, sterile and esoteric".²⁰ She further states that in this circumstance the profession will be forced to look elsewhere for the answers to its questions and that such reliance on other professional disciplines blurs identity and stunts autonomy, "subjugating us to the perspectives, priorities and power of others".²⁰

Algate considers the role of faculty practice essential in advancing the discipline. She sees this as much more than simply maintaining clinical competence. She believes it is essential that clinical scholarship be the focus of faculty practice. However, credibility through clinical competence is also considered an important component in enabling knowledge and research findings to be used in the clinical setting. Algate warns that unless academics root themselves in practice, the development of their profession as a discipline could be in jeopardy.²⁰

DISCUSSION

In the years since midwifery education has been incorporated into post-secondary educational institutions, a theory-practice gap has been identified



in midwifery and nursing education. It is reported that midwifery and nurse educators have felt an urgent, sustained need to establish their academic credibility to the detriment of clinical practice.^{8,20,29} Articles and position papers in several countries clearly identify that clinical credibility is as important as academic credibility and many professional bodies recognize its importance.^{6,8,30,35,37} The Council of Deans and Heads of UK Faculties of Nursing, Midwifery and Health Visiting states that the current situation is untenable for evidence-based professions.⁴¹ Pegram and Robinson comment: “-- to others outside of the profession it must seem unimaginable that teachers of a practice-based discipline are themselves not engaged in practice in a coherent and meaningful way.”⁴¹ The division between the desired goal of a professional model of practice and current management models in health care pose significant barriers and may prevent professional growth and independence. I would suggest that this is particularly so where midwifery and nursing are closely linked and function primarily in an employee situation.

The professions and the educational institutions do not yet acknowledge there are serious implications for an educational institution that is considered by practitioners to be out of touch. We are warned that unless academics root themselves in practice, the development of their profession as a discipline could be in jeopardy. The role of health professions' educators in influencing clinical practice is an important one. If we believe that practice is core and theory is generated from practice, then we must have structures within the clinical setting and educational institutions that allow us to maintain and develop the academic's clinical expertise. Educators must be able to incorporate the changes to clinical practice within the larger context of the health care system in order to improve midwifery practice. Maintaining their identity as practitioners is seen as a fundamental way to achieve this.

Studies reviewed uniformly state that midwifery educators must demonstrate clinical competence in order to enhance the pursuit of the discipline's scholarship and advancement of the profession. It is important that the practice requirements of regulatory bodies acknowledge the expertise inherent in the academic's role as a component of clinical

competence and recognize this as contributing to regulatory practice requirements. Not to do so will simply add further unreasonable expectations to the workload and personal and emotional demands midwifery educators already experience. This may eventually overwhelm the most enthusiastic academic.

CONCLUSION

Recommendations for change in midwifery and nurse educators' roles have been made over the past 15 years by professional bodies and concerned health professionals in several jurisdictions. This includes the expectation that educators will be allowed to regain their clinical skills and to maintain their clinical expertise. Such expectations require professional and system changes.

The research literature reviewed communicates a sense of urgency about this issue. Government, regulatory bodies, practice agencies and education institutions must address this issue by developing a strategic, comprehensive, management plan for the practice role of midwifery educators. If midwives in Canada wish to continue to be viewed as primary health care professionals on an equal footing with medicine, we would do well to note these requirements.

Canadian midwifery is unique in re-introducing a historically rich tradition within a contemporary context. Our vision for the profession has challenged the entrenched attitudes of more established midwifery professions in other countries. They are watching the course we take and we should, in turn, be open to the strategies they use to meet their educational challenges. The concerns in the international midwifery community identified by this literature search should inform future discussions on the direction that Canadian midwifery education should take.

AUTHOR BIOGRAPHY

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