The transition from clinical practice to education

After 20 years in clinical practice (initially as a registered general nurse and then a registered midwife), a secondment opportunity presented to take up a role as a practice healthcare lecturer at the University of Nottingham. I am interested in midwifery education and was already practising as a clinical educator and mentor to student midwives, so this seemed an excellent opportunity to experience midwifery education from an academic perspective. Despite being a senior midwife and expert labour suite clinician, the role as a novice educator was a daunting prospect and required a period of transition from clinical practice to academia McDonald (2010). This article focuses on making the transition, and provides advice to anyone looking to make a similar career change in the future.

Abstract

Every midwife will make the transition from education to the clinical setting, but moving from clinical practice to a new role in midwifery education can be just as much of a change. The decision to transition from clinical practice to a midwifery academic educator role should be carefully considered. As part of the midwifery education in action series, this article will reflect on the authors' own move into education and share these experiences with those who may also wish to choose this career path. After more than three years in post, there is much to be shared; however, this article will also include a brief review of midwifery education, how best to support student learning and assessment, and how to prioritise career development.

Keywords

Transition | Midwifery academic | Midwifery education | Clinical practice | Educator | Healthcare education

Midwifery education today

It is important for academic educators to be aware of the socio-political landscape regarding higher education and healthcare provision. Midwifery education in the UK has seen a number of developments, from the regulation of the profession and the Midwives Act in 1902 to the present day, where midwifery education is well established in universities. Further changes are still to come, with the review of the new standards for pre-registration education by the Nursing and Midwifery Council (NMC, 2009). Gorski et al (2015) argues that there have been huge changes in healthcare provision but that healthcare education has been slow to change in the face of social and scientific advances.

Quality is often linked to value, and a current buzzword is 'values-based education' (Russell and Williams, 2017). This was examined in a review of pre-registration nurse education and its effectiveness, especially between classroom and clinical placement learning (Department of Health, 2012). The findings were that there were no shortcomings in nursing and midwifery education, although recommendations were made, primarily that patient-centred care should be put at the heart of all pre-registration education and professional development. It is therefore important, as academic educators, to appreciate the recommendations from the Willis Report (Department of Health, 2012) when planning curricula, modules and individual sessions.

In developing curricula, many institutions aim to allow students to engage with service users during a wide range of activities in midwifery education. As an experienced clinican transferring to an educator role, I was able to bridge the gap between the students I taught and the women I met in practice. I felt comfortable in engaging service users, and also that this was a role in which I could develop further confidence. As a result, over the past 3 years in education, I have included a number of service users in lessons, which has proved to be a hugely rewarding experience, both for the service users who take part and the students who learn from them. I would encourage those entering education from clinical practice not to lose focus of the importance of service user experience and to consider how they are best placed to offer their experiences and expertise in high quality midwifery education provision.

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Transferring from clinical practice to education can be daunting, but those making the move should remember that their links to service users can be a valuable resource for students

Financial impacts for student midwives

From September 2017, UK universities are now charging undergraduate student nurses and midwives tuition fees for the first time. The Government has also axed the student bursary, a move that was strongly opposed by the Royal College of Midwives (RCM) (Dabrowski, 2017), who raised concerns that midwifery may lose its diverse student population. As facilitators of a vocational course, educators must appreciate that healthcare students do not have the autonomy to engage in extracurricular employment to help fund their studies. Undergraduate healthcare programmes demand that students are flexible to meet the competing demands of the course, which may include intense theory study blocks, assessments, regular work placements with travel demands and shift patterns, together with independent living and adaptation to university student life. As a personal tutor, this is the area where I feel most limited in my capacity to signpost students for support. My advice to new educators is to have a broad knowledge of the financial pressures that healthcare students will face. My fear is these will worsen, and that there is a rise in attrition as students are unable to cope with the financial burden. The RCM (Dabrowski, 2017) have argued that the shortage of 3500 midwives in England will be further impacted with this dramatic shift in the system. Furthermore, the contentious introduction of the Teaching and Excellence Framework (Health Education Funding Council for England, 2017) may also have a bearing on the increase of tuition fees in the future. Educators must therefore continually question the system and look for signs that students are not coping financially, in order to offer support and advice before students reach a crisis point.

Supporting student learning

Having worked for the NHS for all of my career, I noticed a change in objectives when I moved from clinical practice to academia. The main aims for clinical midwives are to ensure that childbearing women receive the highest standards of care, and that organisational demands are met. As an academic educator, the demands of the role can be largely focused on divisional workload. As a novice, I felt it was easy to lose sight of the bigger picture, so I maintained regular clinical practice. These shifts allowed me to return to a domain where I felt confident and credible. Looking back, this was a really essential aspect of my growth and development into education. It gave me time to consider the best way to transition and build the emotional resilience required to move into a different role with the support of both clinical and academic colleagues.

Maintaining links to clinical practice is essential. Learning happens in both the classroom and clinical setting, so it is important to use every possible opportunity to ensure regular and productive student contact. Inspiring, engaging and empowering students

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to take learning beyond contact time and to embrace the opportunities that the course offers is key to both their educational and future professional development. Knowles (1990) highlighted how adult learners need to know why they need to know something, making it relevant to their own practice. Encouraging reflection, critical analysis, and offering a 'where next?' option at the end of meetings and sessions further aids engagement with the learning process. In addition, ensuring that students feel able to discuss difficult issues that may have a detrimental effect on their learning is a key part of supporting them through their course journey.

Robinson et al (2012) suggest that students prefer face-to-face communication, rather than using technology. However, I have used Skype on occasion when supporting students who do not live locally, including those on ERASMUS and overseas placements, and have found it a beneficial resource. Technology was an area where I quickly identified a need to improve my understanding as how it might be best employed as a tool for teaching and learning. I sought further training in order to develop my both my knowledge and confidence, and would urge new educators to use technology as appropriate to support your role in education, as I have come to realise there are many responsibilities I simply could not fulfil without it.

Pastoral support as an academic

One area that I feel has been significant in my professional development is that of student pastoral support. I am a personal tutor for 19 undergraduate students and seven postgraduate students, as well as those that I teach and meet in the clinical practice setting. Walsh (2014) advises that the more interest educators show in students, the greater the students' confidence and self-esteem. The relationships that I have developed with my students has, for the most part, proved mutually rewarding, in that I have learnt as much from them regarding university life as they have hopefully gained from the many varied ways I have been required to support their learning.

Students who are drawn to vocational courses can often bring very unique demands that require sensitive and individual response, and one of the most difficult aspects of my role as a personal tutor is remembering that the best way to resolve issues is often to signpost students to access support, advice and guidance from a variety of resources. At the beginning of my first year, I became overwhelmed by the sheer volume of challenges presented by some of the more vulnerable students whom I was supporting, and I became quite distressed as a few were experiencing particularly serious difficulties. However, I was very fortunate to have the support of an excellent mentor and experienced colleagues, who offered sound advice and guidance that helped me to support the students. I now have a wider understanding of the institutional support mechanisms available and how I can signpost students to access support strategies and services. As these students are adult learners, I must advocate a self-autonomy for students and not apply a paternalistic approach, although my natural instinct to help, nurture and offer resolution means I have found this very difficult. I therefore sought the opportunity to better understand the student fitness-to-practice guidelines, and familiarisation with the various strategies and resources at my disposal enabled me to better support students to access help according to their individual need. My advice to those entering healthcare education is that you already possess many of the skills needed to support students as mentors; however, in order not to become overwhelmed, it is important to access appropriate training in supporting students, in order to know what resources are available to help students with the wide variety of issues they may present. I now feel better equipped to support student learning and have a wider appreciation of my role as personal tutor.

‘Inspiring, engaging and empowering students to take learning beyond contact time and to embrace the opportunities that the course offers is key to both their educational and future professional development’

Assessing and feedback

Before working in higher education, my experience in assessment and feedback was mainly based around my roles as clinical educator and preceptorship midwife. This was a clinically-based form of assessment and feedback was generally verbal. However, despite feeling rather daunted by the prospect of a more structured assessment and feedback approach, I drew on my previous experience to support this new venture. Over the past three years, I have been involved in a number of different student assessments and feedback opportunities, including both summative and formative assessment. The first evaluations that I experienced were formative written assessments, and as a novice teacher, I was offered the opportunity to 'shadow-mark' documents with a more experienced lecturer in order to develop confidence. Quinn and Hughes (2013) state that regardless of method, assessment must meet the four essential criteria: validity, reliability, discrimination and transparency. Support with marking proved extremely helpful as I became aware of the subjective nature of assessment. Race (2006) suggests that students do not tend to read their assessment feedback, and favour just noting the grade; despite a

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Key points

- Moving to a role as a novice educator from one as an experienced clinician can be a daunting prospect and a journey of transition
- It is important for academic educators to have an awareness of the socio-political landscape regarding higher education and healthcare provision.
- Patient-centred care must be at the heart of all pre-registration education and professional development
- Tuition fees and the removal of the student bursary may result in a smaller and less diverse student body. Educators should observe for signs that students are not coping financially and offer support and advice
- Maintaining links to clinical practice is essential. Clinical placements should be used to enhance student learning and bridge the theory-to-practice gap
- Review student feedback should be reviewer to ensure that teaching, learning, assessment and overall experience meets expectations.ß

study by Hepplestone et al (2010), who suggested that students appreciated feedback on identified weaknesses. The National Student Survey (NSS) rates feedback as the lowest performing category across higher education institutions (Quinn and Hughes, 2013). Race (2014) concluded that this is as a result of feedback comments being misinterpreted and students lacking understanding of how to use feedback to improve their future work. I now shadow-mark with less experienced colleagues and I have learnt to ensure that appropriate timeframes for marking are applied, as it is a time-consuming area of professional development.

Student feedback

Just as in clinical practice, I endeavour to always reflect and develop my skills in order to meet the changing demands of future students. Biggs (2011) concludes that expert educators continually reflect on how they might improve their teaching by collecting and using feedback. At the University of Nottingham, there is a quality assurance process and a system whereby student evaluation of teaching and modules are reported. I review my student feedback to ensure that my teaching meets expectations, and I use that feedback to grow and improve, both in terms of my approach and content delivery. A case in point has been my initiative to use of clinical placements to enhance student learning and bridge the theory-to-practice gap.

Planning career development

Becoming an academic educator requires careful, long-term planning, considering financial implications, scholarly activity and career opportunities. It is not unusual for clinicians who become educators to have to adjust to a reduction in their salary. My seconded role led to a permanent position as a Level 4 Midwifery Teaching Associate and more recently to a Level 5 Assistant Professor role; however, I still have not met the NHS salary level that I left three and a half years ago. It is also important to consider pension schemes when leaving the NHS for a role as an academic as in all likelihood, the age of retirement will shift to beyond 65. Nevertheless, compared with the punishing demands of irregular shift patterns, the work-life balance as an educator is overall far more positive.

Scholarly activity and growth through the Post Graduate Certificate in Higher Education (PGCHE) is essential in order to understand teaching and learning theories. This was a well-supported opportunity, with funding and time provided as part of my role. Since qualifying as a midwife in 1999, there have been few gaps in my ongoing engagement in scholarly activity, so I did not find it overly difficult to meet the demands of postgraduate education. I re-engaged with the excellent *Good Study Guide* (Northridge, 2007), and planned my workload accordingly. As an educator, I learned about the planning and protection of scholarly activity, and there have been a number of occasions where I have taken on extra work or covered for staff absences to the detriment of my own development. Going forward, I am now more strategic in planning time to ensure that personal development is a priority. My advice to others in a similar position is to consider this an essential aspect of the role. It will be an expectation of the higher education institution as well as a requirement for NMC revalidation, and will be evaluated at your annual performance review.

On entering the role in education, I would further recommend a 5-year development plan with an academic mentor. This is an excellent opportunity to consider your role within your department, the wider school and the university. It affords you the opportunity to develop and progress into a more senior position, and to consider how day-to-day professional practice may inform and inspire productive scholarly activity. You need to be proactive in your pursuit of career development and this approach does not always come readily to clinical midwives who are more familiar with working as a team.

Summary

As educators at higher education institutions, we face a perennially changing, extremely challenging socio-political landscape, and it important to keep well informed and politically aware. Brexit and the UK post-election challenges will continue to test our role as educators and as midwives. Alongside this we are still awaiting the NMC's new Standards for pre-registration education (NMC, 2009). We need to be aware of the financial pressures that students may face and challenge the support that they are offered to ensure that it meets their individual needs.

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Being an effective academic educator is not just about applying general teaching principles. The role needs to be adapted according to personal strengths and teaching context, and should always include service users. National and global health and educational directives demand that midwifery educators must apply their knowledge of evidenced-based practice, teaching and learning theories and styles, and appropriate student assessment to future curriculum developments (Knowles, 1990). Additional tasks, such as prioritising work, supporting students and planning career development, should also be supported by an academic mentor.

I have offered my perspective on transitioning into education and it is imperative as midwifery academic educators that we use the opportunities that the current climate presents to ensure that midwifery, both as a profession and within education, is placed in a strong, sustainable position. We must endeavour to support student diversity and provide opportunities for them to develop as resilient future midwives. Student midwives should be able to embrace their future careers and become strong leaders and future agents of change, ensuring that care for childbearing women meets the highest possible standards, both nationally and internationally. BJM

CPD reflective questions

- Have you ever considered moving from clinical practice to education?
- What are the implications of transitioning from midwifery clinical practice into academic education?
- How could you seek support as a novice midwifery academic educator?
- Will you have the opportunities to seek career development?

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