

# The tensions of the modern-day clinical educator in physiotherapy: A scholarly review through a critical theory lens.

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## ABSTRACT

Clinical education is central to the education, registration and professional socialization of student physiotherapists. The role of clinical educators is crucial. They are, however, subject to powerful influences, pressures and tensions. This paper offers an appreciation of the clinical educators' sources of tension and conflict, particularly with respect to the unique relationship between clinical educators and other stakeholders in physiotherapy. Using a critical theory lens, this discussion is framed in the work of French philosopher Pierre Bourdieu [1930-2002]. Through Bourdieu's concept of social space and in particular *distinction* and *differentiation*, tensions and conflicts are explored. *Distinction* refers to the positioning of social groups relative to each other; the greater the space separating the groups, the greater the source of tension. *Differentiation* relates to two key principles of economic and cultural capital. Education providers could be considered owners of economic capital as opposed to healthcare providers who predominantly possess cultural capital (professional culture). Less tension and conflict exists when the capital is of equal value. The demands on clinical educators is multi-dimensional; the urgent need to educate a workforce to meet future healthcare demands (professional), increased demands for placements (educational) and service demands, prompt a timely constructive critique of clinical education. **Mooney S, Smythe L, Jones M (2008): The tensions of the modern-day clinical educator in physiotherapy: a scholarly review through a critical theory lens. New Zealand Journal of Physiotherapy 36(2): 59-65.**

**Key words:** clinical education, clinical educators, supervisors, tensions, critical theory, Bourdieu

## INTRODUCTION

Clinical education (CE) is the means by which student physiotherapists, the workforce of the future, develop the attitudes, knowledge, skills and competence to take their place in the profession (Baldry Currens and Bithell 2000; Rose and Best 2005). It is considered an essential component (Moore et al 2003; Ohman et al 2005) of physiotherapy practice and is a mandatory requirement to meet standards determined by professional registration bodies. CE however is a complex entity and is based on a unique relationship between many stakeholders. These include Schools of Physiotherapy, professional leaders (PLs), service managers and students. However the primary responsibility lies with the clinical educator to educate students within the unique setting of clinical practice. Clinical educators are "senior, qualified, practising physiotherapists whose role is to supervise, facilitate and assess students' learning while they are on placement" (Moore et al 1997 p.7). They play a pivotal role in the education of students yet may be subject to the multi-dimensional pressures exerted from stakeholders (Baldry Currens and Bithell 2000) that have an interest and differing degrees of power and influence in CE (Figure 1). The term 'clinical

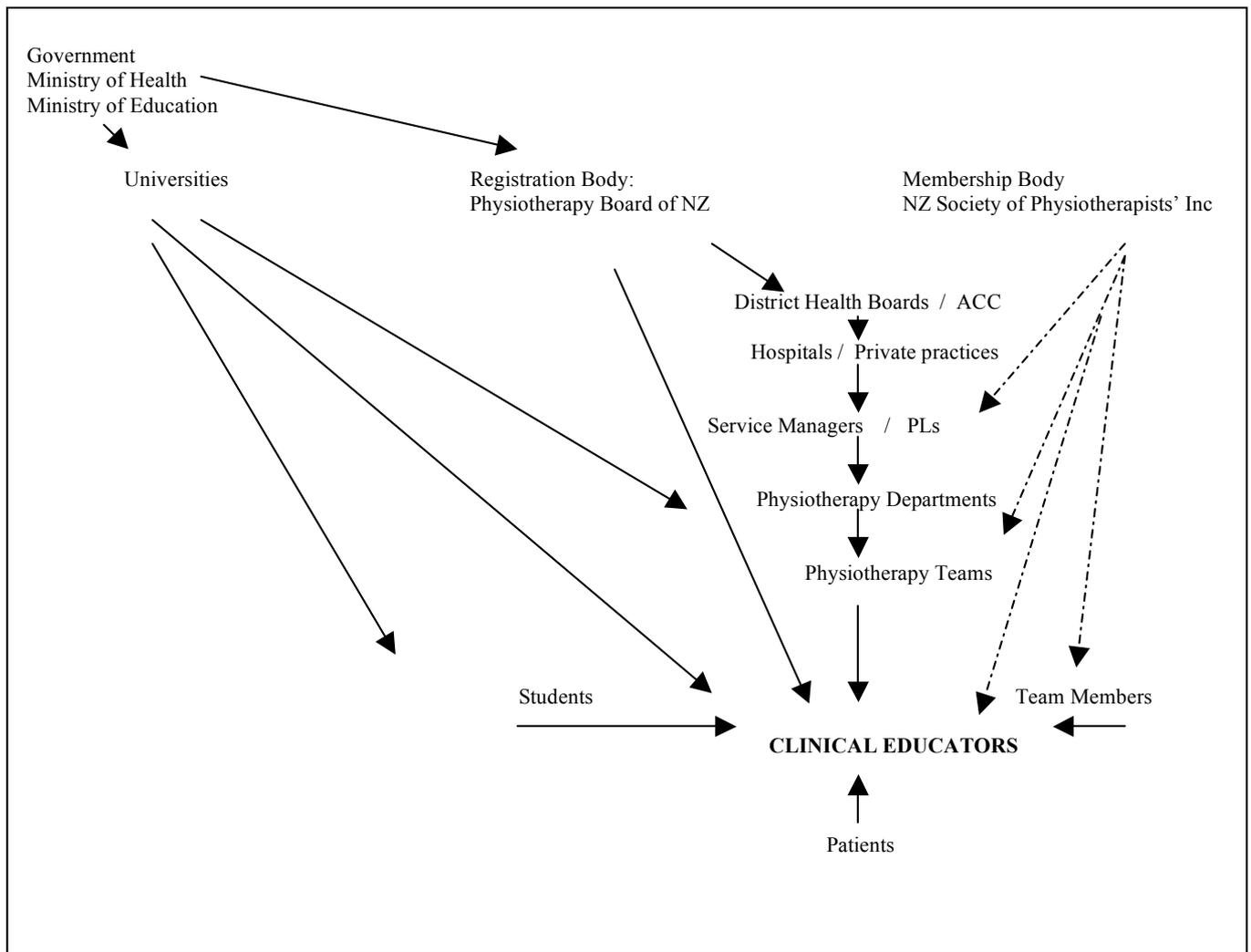
educator' according to Rose and Best (2005) is "a relatively new term" (p.3) and its use may vary between Schools of Physiotherapy. For the purpose of this review the term 'clinical educator' will be used to describe a physiotherapist who a student most closely works with and is responsible to, in the clinical practice setting.

There is a limited body of research that captures the perceptions of clinical educators regarding their role and the tensions they may experience. The national and international shortage of clinical educators and clinical placements prompt this timely review as their scarcity impacts on the workforce of the present and the future (Baldry Currens and Bithell 2000; Moore et al 2003; Ohman et al 2005). The aim of this scholarly review is to offer an insight into some of the sources of these tensions through a critical theory lens guided by the work of Bourdieu, a French philosopher. It is through the appreciation of these tensions for clinical educators that any future changes to CE should be explored.

## LITERATURE REVIEW

A literature review was undertaken using combined key words of clinical education,

Figure 1. Different stakeholders in CE in physiotherapy.



NB: Membership to the NZ Society of Physiotherapists' Inc. is optional and therefore the relationship of stakeholders to the Society has been represented with a broken line.

supervision, educators, tutors, supervisors, clinical teachers, perceptions, stakeholders, physical therapy and physiotherapy. These were entered into medical, education, nursing and allied health databases. The focus of the literature review was the perceptions and views of clinical educators relating to their role, and the relationship between clinical educators and other stakeholders in CE in physiotherapy. Results indicated a small volume of research.

Much of the literature identified related to the sustainability of CE in the current healthcare system in light of clinical placement shortages. This was attributed to the growth in student numbers (Baldry Currens 2003), dwindling numbers of senior staff (Moore et al 2003) and the increase in Schools of Physiotherapy (Crosbie et al 2002). Literature was also found which discussed the benefits of peer learning, and the productivity of students in the workforce (Ladyshevsky 1993, Ladyshevsky et al 1998, O'Sullivan et al 2007). There was limited discussion within this research that captured the specific perceptions of clinical educators of their role or their relationships with other stakeholders.

Only two studies in the last decade have solely focused on the perceptions and views of clinical educators in CE in physiotherapy: Ohman et al (2005) investigated clinical supervisors' perceptions of professional role, physiotherapy education and the status of the profession in Sweden; and Kell and Jones (2007) explored the perceived conceptions of teaching by placement educators in Wales, United Kingdom (UK).

### Clinical educators: perceptions of their professional role and qualities

The role of clinical educators has evolved over the past few decades prompted by the establishment of degree programmes, developments and restructuring of healthcare services and the increased need for graduate 'readiness to work'. The role of CE however remains alongside the clinician's primary role of providing effective patient care and is reliant on the motivation of individual clinicians to take on this role (Kell and Jones 2007, Ohman et al 2005); this perception is reflected in the available literature.

Clinicians who are involved with CE have been identified as highly motivated, and exhibit

strong commitment and responsibility to educate competent practitioners, yet experience personal stress when the demands of both roles come into conflict (Kell and Jones 2007, Ohman et al 2005). Different conceptions of teaching may be influenced by years of experience and can give rise to tensions between educators and educationalists regarding how clinical educators are prepared for and supported in their educational role (Kell and Jones 2007). Pressures on time together with tensions between the educators and other stakeholders in CE i.e. managers, have also resulted into low morale and job dissatisfaction (Ohman et al 2005).

The impact of differing perceptions of student, clinical educator and academic staff on what constituted the 'ideal clinical educator' was the focus of study by Cross (1995). There was little congruence found between their perceptions in general, however students' and clinical educators' perceptions were noted to be closer compared with academic staff. Although the results were not found to be significant, the conflicting aims and expectations between educators and academic staff, "with the students in the middle" (Cross, 1995, p.512) were sources of tension. These differences in perceptions were thought to be influenced by differing traditions, roles and expectations in CE.

### **Clinical educators: relationships, expectations and tensions**

The roles and expectations of senior physiotherapists include the provision of a quality and progressive service to their area e.g. cardio-respiratory, supervision of rotational/new members of staff, developing/updating policies and procedures and participation in audit/research. In addition to these responsibilities, there is the expectation that they will supervise students as CE is considered integral to their role (Ohman et al 2005). This expectation has also been reflected by the Physiotherapy Board of New Zealand (NZ); student supervision does not directly contribute towards continuous professional development (CPD) activities (Godsall and Beggs 2006) unless specific learning experiences are demonstrated. In addition, NZ Health Strategy (Ministry of Health 2000) has stated that 'teaching' is integral to any healthcare professional's role and suggests that job descriptions make explicit the role of education in the workforce.

Clinical educators in the study by Ohman et al (2005) felt that although CE was considered "extremely important" (p.117), managers did not appreciate the impact of students on time or working conditions. They also identified a lack of managerial support and leadership for clinical educators. In addition, they felt they were "often forced to take on supervision of students" despite informing managers and university staff, that it was not an ideal time to have students. The lack of support for clinical educators and the cancellation of placements however may highlight tensions

also experienced by managers. Baldry Currens and Bithell (2000) investigated the attitudinal and organizational barriers to clinical placements in one region in the UK. Managers voiced their commitment to CE however this commitment was compromised by their responsibility and requirements to provide a physiotherapy service to their employing authority. The authors concluded that the perspectives of the different stakeholders interviewed (service managers, clinical educators, recently qualified physiotherapists and third year physiotherapy students) were influenced by different pressures, unique to each stakeholder.

The study by Cross (1995) into the perceptions of the 'ideal' educator found the implication that "the existence of good clinical educators is the major factor in ensuring good clinical education" (p.506). This potentially places additional pressure on the clinician to ensure that the student has a positive learning experience, regardless of other commitments and obligations to the immediate team or department. Clinical educators described feelings of stress from "time constraints and trying to accommodate all aspects of their duties in addition to students" (Baldry Currens and Bithell 2000 p.649). This was compounded by the clinicians' reluctance to delegate their caseload to students, which Ladyshewsky (1993) and Ladyshewsky et al (1998) have found essential to compensate for time dedicated to student learning and to minimize stress.

Increasing responsibilities, together with constant change within the healthcare system and pressures to provide quality placements, may have contributed towards a number of senior therapists leaving the workforce. As a predominantly female profession (Ministry of Health 2004), career breaks linked to family life are common, with only a proportion of 'mums' returning to full time work. The number of senior clinicians (and in particular, full time clinicians) appears to be dwindling which, with the growth of student numbers and schools of physiotherapy, contributes greatly to the scarcity of clinical placements (Crosbie et al 2002, District Health Boards NZ 2006, Ministry of Health 2004, Moore et al 2003, Taylor et al 2006). The shortage of senior staff also impacts on service delivery and development, recruitment of staff and the ability to support junior staff, whom are often recruited when senior positions cannot be filled. The demands and stresses on remaining senior staff have therefore clearly increased (Ministry of Health 2004, Taylor et al 2006).

In summary, the perspectives of clinical educators specifically relating to their professional role have been the primary focus only in the study by Ohman et al (2005). Other research however does allude to some of the challenges and tensions faced by clinical educators and calls for improved collaboration between stakeholders, support by managers and university staff to facilitate CE within the practice setting (Baldry Currens and Bithell

2000, Crosbie et al 2002, Cross 2005, Jones et al 1998, Kell and Jones 2007, Ohman et al 2005, Ministry of Health 2004, Moore et al 2003).

The tensions which have been identified and discussed within the literature will now be explored further through the lens of critical inquiry and in particular the work of Bourdieu.

### Pierre Bourdieu [1930-2002]

Critical inquiry analyses all dimensions of social reality e.g. its culture, power interplay including social, economic and political relationships and aims to empower groups by means of raising their awareness to power imbalances. In this context, Bourdieu explored the logic of classes and society. He believed that through an appreciation of the empirical reality which is historically located and dated, the social world under review can be appreciated. He constructed several theories, one of which was a theory of social and symbolic space based on the principles of *distinction* and *differentiation*.

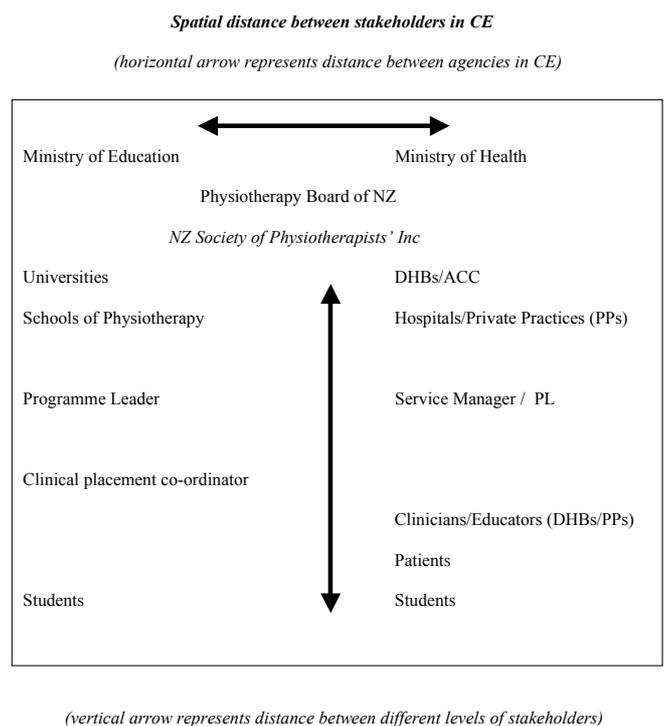
### Distinction

*Distinction* describes how social space determines how different groups are placed within the space or field, e.g. clinical educators and managers are positioned differently within the 'field' of physiotherapy. Bourdieu advocated that "spatial distances on paper are equivalent to social distances" (1998 p.5) Groups are positioned within the field based on "proximity, vicinity or distance as well as through relations of order such as above, below and between" (Bourdieu 1998 p.5). The idea of different degrees of space between groups either horizontally or vertically, represents potential sources of tension (large space) or congruence (small space). Figure 2 positions stakeholders in CE using Bourdieu's principle of distinction which, in this instance, relates to their direct level of communication, accountability and responsibility.

The horizontal positioning of key investors and agencies concerned with CE (Figure 2) shows government bodies, and students - the consumers of healthcare education - at opposing ends of the continuum. Government bodies such as the Ministry of Health influence healthcare service and delivery. The student possesses little or no power in solely influencing policy at an organizational, governmental or ministerial level, yet changes in funding and healthcare have a direct impact on individuals. Similarly, physiotherapy departments and individual clinicians are spatially removed from government bodies, and therefore their ability to elicit change is minimal. Their source of tension and potential for conflict is great as there is a large spatial gap between them.

In contrast, clinical educators are closely positioned with PLs who are themselves physiotherapists. There is a stronger sense of identity with each other, albeit that their roles are different. Similarly clinical educators who are

**Figure 2. Stakeholders in CE positioned relative to each other (adapted from Bourdieu's principle of distinction).**



senior clinicians can relate to clinical placement co-coordinators, employed by universities, as they are also physiotherapists and also spatially located in proximity to each other, although the existence of distance between the two suggests that their relationship can also be a source of tension.

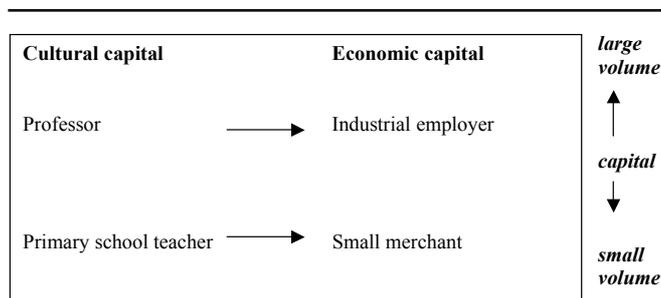
Students are positioned near to clinicians. This may be one reason why clinicians play an important role in role modeling and the professional socialization of students (Cross 1995, Ohman et al 2005). They are able to identify with clinical educators (clinicians) as the skilled and qualified practitioners they will soon be. Clinical educators are similarly able to identify with students as the future workforce. However the assessment process determines the existence of space through the definition of the roles and responsibilities of the clinical educator and student which can represent a source of tension and conflict.

### Differentiation

*Differentiation* also determines how groups are positioned relative to others. The overall possession and relative weight of different kinds of capital (power) influences where and how the groups are positioned. Capital is described in terms of symbolic, political, economical and cultural power found in fields. For example, Bourdieu (1998) cites a professor as being wealthier in cultural capital compared with an industrial employer, who is relatively wealthier in economic capital. These differences can also be observed elsewhere in the social hierarchy e.g. primary school teachers and small merchants, wherein the same horizontal distance would exist both between a professor and industrial employer, and a primary school teacher

and a small merchant. The only difference is that professors and industrial merchants would be placed higher in a hierarchical position due to their possession of larger amounts of different capital (Figure 3).

**Figure 3. The hierarchy of different professional groups based on the possession of capital.**



The different investors in CE in Figure 2 are positioned in a hierarchical manner within the field of CE, relative to their perceived possession of capital. Agencies such as the Physiotherapy Board of NZ, DHBs and physiotherapy departments have not been placed at a level equal to the NZ Government (Ministries of Health and Education) for the 'State' controls policy and resources, unequal to all other agencies. The Government's power is political, social and economic as it has the power to for example, restructure the healthcare service. Although DHBs report and are accountable to the Ministry of Health, they provide a service to the community, include consumer representation and make up a large volume of workforce. The power of DHBs lies in cultural capital; their economic capital determined by the Ministry. The hierarchical positioning of physiotherapy clinicians/educators relative to DHBs and also clinicians relative to practice/service managers and ACC, demonstrates equality amongst practitioners.

The Physiotherapy Board of NZ (the Board) is positioned equidistant between Ministries and education/health service agencies. The Board's role is to ensure the safety of patients, regulate the practice of physiotherapy and determine competencies required for registration. The role of the NZ Society of Physiotherapists Inc. (the Society) is to represent the physiotherapy profession particularly at a policy level and represents a membership of physiotherapists. The Board is positioned at a higher level than the Society, as registration is mandatory, whilst membership to the Society is optional. There is communication between the two groups in the forms of committee membership however with regard to CE, the Board may have greater political power (as it determines requirements of registration including the number of competencies and clinical hours to be completed) and economic capital (as it determines registration fees). The Society however does hold a large amount of cultural capital and therefore has some political power, as it represents a body of physiotherapists who have subscribed to the Society.

Universities and Schools of Physiotherapy possess large amounts of economic capital in the field of CE compared with DHBs and physiotherapy departments. This is because universities currently fund placements or employ staff specifically to educate students in different healthcare settings.

At a local level, PLs employed by DHBs are registered physiotherapists and hence possess primarily cultural capital. They possess some social power and to some degree, political power as they are in a unique position to represent their workforce and also represent and influence their service/department/DHB at physiotherapy advisory committee level.

The role of the PL is offset by service managers who are managers employed by DHBs/private practices to provide either physiotherapy-specific or allied health services. Service managers are not necessarily physiotherapists. They can therefore bring a different cultural power from their own discipline perspective, which adds to the complexity of the field of physiotherapy and, in particular, CE. Service managers may possess social and political power, which they bring to a different field compared with the PL i.e. service development and strategic planning meetings. They also hold budgets and therefore possess economic capital. The possession of opposing capital, as perceived by Bourdieu, may result in great sources of conflict and tension between the service manager and PL.

Further removed is the student. Although students have representation at a student union level both within the university and also Society, they possess neither cultural nor economic capital. As a consumer, a fee payer, they hold a unique position within the schema, however their position relative to other stakeholders demonstrates how little power they possess.

### **The unique position of clinical educator**

Potential sources of tension and conflict affecting clinical educators are highlighted by their position in the field of physiotherapy relative to other stakeholders and the amount and type of capital they possess.

Clinical educators are positioned close to patients, students, PLs, service managers and clinical placement co-ordinators but distant to other stakeholders such as the Ministry of Health or Education. The existence and extent of space between the clinical educator and for example, PLs and service managers, may result in tension. For example, as a clinician/clinical educator they are sensitive to the two potentially opposing forces of professional and service demands and are responsible and accountable to both. Clinicians are 'employed' by service managers, whose budgets fund and support physiotherapy positions and often developments, yet they are also responsible to PLs for their practice within the clinical setting. This not only reinforces the potential for conflict and tension between PLs and service managers, but

suggests that the clinician/clinical educator may be subject to tensions arising from their relationship and also their own relationship with each individual stakeholder.

Furthermore, clinical educators are positioned between students and patients, the former being the consumer of healthcare education and the latter, the consumer of healthcare practice. The student is required to demonstrate competencies outlined by the Physiotherapy Board of NZ and University and it is the clinical educator who provides access to the experience. Ultimately the clinical educator is employed as a clinician to provide a physiotherapy service; their secondary role is that of CE. Clinical educators therefore are positioned in closer proximity to patients compared with students. The existence of distance however alludes to potential sources of tension when clinical educators are obliged to provide a positive learning experience for the student, yet patients have the ultimate power through their consent of the experience.

The type and volume of capital clinical educators possess also influences where they are positioned relative to other stakeholders. In the context of CE taking place within clinical practice, clinicians may possess more cultural capital compared with, for example, academic staff. Although many lecturers in physiotherapy are registered physiotherapists, their primary role is within the academic arena rather than clinical practice. Therefore the volume and relative weight of their cultural capital in the practice setting may be less than that of clinicians.

Clinical educators as healthcare providers in hospitals/practices/communities possess no economic capital. The funding of placements is generally not paid directly to the clinicians providing clinical education.

The degree of political power clinical educators possess may be unique to their organization. They may be able to determine when and how many students they will supervise, but as CE is becoming embedded within the role of all healthcare professionals (Ministry of Health 2000, Ohman et al 2005) they are expected to supervise students and are therefore less able to influence student placements. There is no special interest group for clinical educators specifically in NZ [see Invited Commentary – Ed.], which limits their political power as they have no collective voice.

## CONCLUSION

The work of Bourdieu allows CE to be explored from a unique perspective. It allows an insight of how spatial positioning of stakeholders and their ownership of capital can influence relationships and become sources of tension. Through this appreciation together with an insight into the literature, tensions can be unraveled and opportunities can be explored to address sources of tension for the modern-day clinical educator in physiotherapy and also CE. The clinical educator

is pivotal to student learning in the workplace, and may be sensitive to many of these tensions, in particular those exerted from stakeholders positioned in close proximity, such as patients, students, PLs and service managers. Factors within the field of CE also exert tension on the clinical educator; this includes dwindling numbers of experienced senior clinicians, demoralized staff, changing and restructuring of healthcare and changing professional requirements.

It is evident from the literature that issues within CE in physiotherapy (Baldry Currens 2003, Jones et al 1998, Moore et al 1997, Ohman et al 2005, Stiller et al 2004) and CE in healthcare in general (Ministry of Health 2000) require urgent attention. Responsibilities lie with both education and healthcare providers to ensure that not only is there a workforce for the future, but that the workforce possesses skills appropriate to providing a quality service, and surviving within a system which is undergoing constant change. Improved collaboration and communication between agencies which are positioned in close proximity and possess similar capital can help minimize tension and promote a positive way forward. Stakeholders who possess in particular political and economic capital, e.g. heads of schools and the Ministry of Education; PLs, service managers and the Ministry of Health, should exert their influence on other stakeholders, in order to influence the direction of CE. The power of the clinical educator may be greatly enhanced by the formation of a special interest group which would give educators a collective voice at a local/national/international level. This would enable clinical educators to have representation at committee level e.g. the NZ Society of Physiotherapists' Inc., and subsequently decrease the spatial gap and increase their capital relative to their current standing.

The recognition of the clinical educator, together with other stakeholders in CE, their positioning within the 'field' of physiotherapy and the type of power they possess promotes a greater awareness and appreciation of the multidimensional nature of CE. There is little research to date which focuses on the perceptions of clinical educators, their role and their relationships with other stakeholders in CE. As their role is paramount to the process of educating students and preparation of the future workforce within the unique clinical setting, it is essential that their perceptions are captured and explored.

### Key points

- Clinical education is a complex entity based on a unique relationship between many stakeholders including Schools of Physiotherapy, clinical educators, service managers, students and patients.
- The role of clinical educators is pivotal to the preparation of the future workforce, yet their perceptions have rarely been captured in the literature.

- An appreciation of some of the tensions clinical educators may experience can be explored within French philosopher Pierre Bourdieu's theory of social and symbolic space, which provides a framework to explore the world of clinical educators in physiotherapy.

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## INVITED COMMENTARY

The scholarly review offered by Mooney et al. (2008) presents a physiotherapy perspective on the tensions generated by the various forces at play in the provision of professional clinical education. The review is a welcome and quality addition to the limited quantity of scholarly resources examining the role of clinician as clinical educator.

The context in which Mooney writes is one in which a failure by the physiotherapy profession to acknowledge the issues addressed may severely compromise the provision of education within the physiotherapy clinical setting. Kell and Jones (2007) recommend an increase in collaboration between educators and educationalists to ensure that clinical educators are prepared for and supported in their role. The New Zealand Health Strategy (Ministry of Health, 2000) describes teaching as integral to any professional's job, and suggests that job descriptions make explicit the role of education in the health care work force.

Yet the changing face of physiotherapy provision in New Zealand, an administration-heavy, remuneration-light culture, has the potential to

undermine the resources required to fulfil the requirements of clinical education. Physiotherapists with the experience and qualifications necessary to impart quality clinical education are tempted by higher salaries and better conditions off-shore, or take on solely administrative or academic roles without a clinical workload. The resulting lack of senior staff who would create a positive learning culture for physiotherapy students, especially in the hospital system, places pressure on more junior staff to absorb some of the teaching load.

In spite of Moore et al. (1997) stating that clinical educators are "senior" (p.7), more and more of the physiotherapists entrusted with the clinical education of undergraduate students are now 'junior'. Not only are these 'junior' physiotherapists requiring mentoring from within the profession to assist their own successful transition to the graduate world, but they now require mentoring and support as clinical educators.

So what can we, as a physiotherapy profession in Aotearoa New Zealand, do to mitigate the circumstances that are eroding the confidence and

capabilities of our clinical education system? How can we facilitate the fulfilment of the objectives outlined above in the New Zealand Health Strategy? How can we promote education as a fundamental responsibility of all physiotherapists, and provide the support that each physiotherapist needs to carry out that responsibility? These are questions the profession cannot afford to ignore.

In the past, as outlined by Mooney et al. (2008), "clinical educators...join special interest groups associated with their area of practice. This limits their political power and effectiveness as [clinical educators] as they have no collective voice." (p. ?). The formation of an Education Special Interest Group (SIG) within the New Zealand Society of Physiotherapists, Inc. (NZSP), would provide both a forum for supporting clinical educators, and a position of spatial strength (à la Bourdieu) from which educators could exert more influence on the profession.

In April, 2008, at the NZSP national physiotherapy conference in Dunedin, the inaugural meeting occurred of physiotherapists interested in the formation of an Education SIG. The response was heartening for the profession, and the process for formally recognising the group within the NZSP has

commenced. It is hoped that the Education SIG will be ratified by the Society at the 2009 Annual General Meeting. The aims of the new group are yet to be finalised, but rest assured that the focus will be on answering the questions posed above, putting Education firmly at the heart of our profession.

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