FUTURE DIRECTIONS: COLLABORATIVE LEARNING AND EDUCATION FOR MULTI-PROFESSIONAL PRACTITIONERS?

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Aim
To explore benefits for multi-professional psychosexual learning, in the context of wider debates regarding medical organisations sharing learning opportunities with post-qualified nurses. To promote the need for cross-disciplinary development embedded within academic credit frameworks.

Background
The theme of the 2014 Institute of Psychosexual Medicine (IPM) conference focused on future educational directions. Conference specifically considered the feasibility and potential desirability of widening IPM's hither-to medical education and qualification to registered nurses and physiotherapists. Three core topics need prior clarification. The first topic centres on the impact of outmoded concepts of "nurse training". The second topic concerns the nature of academic credit and (degree) awards. The latter is especially pertinent in the context of 21st century continuing professional and personal development (CPPD) that aims to improve best practice in client/patient care and associated services. The third is on whether nurses, who undertake a programme of learning provided by medical organisations, should be entitled to the same qualification and post nominal learning provided by medical organisations, should be entitled to the same qualification and post nominal learning.

Discussion
Current and future trajectories of nurse education are firmly set within the developmental philosophies of life-long learning, rooted in a Higher Education (HE) academic framework. Recognising, sharing, and accrediting multi-professional learning, through the reciprocal strengths of clinical excellence and educational expertise, are the ultimate ways to provide the professional and academic lea ring nursing is 'signed up to' and that patients or clients deserve of all multi-pr ofessional and specialist practitioners.

Key words
Continuing Professional and Personal Development (CPPD); Life Learning; Nurse Training; Psychosexual; Academic Credit/Credit Rating.

INTRODUCTION
Current nature of learning and CPPD for nurses
An undergraduate student of nursing explains that: "Education implies an active and developing learning process that involves crucial skills such of those as reasoning and critical analysis, ultimately leading to evidence-based practice. Conversely, the word training connotes the indoctrination of prescriptive instructions and skills" (Britain's Nurses 2013).

If one conducted an imaginary straw poll of various sexual and reproductive healthcare (SRH) professionals in the UK it would undoubtedly reveal that a significant percentage undertook pre-registration programmes of professional education when such learning was popularly referred to as nurse, and sometimes medical, "training". At first glance, there may appear to be no reason to be concerned about this seemingly benign term especially as it is in wide and regular use (Hunt & Onslow 2012). Even SRH professionals too young to have been through the former hospital-based schools of nursing and their “training” programmes are still surrounded by discourses that use "training" as a preferred term (Beddard 2012). As Everett et al. (2013 p.68) accurately made clear, however, "nursing is now a degree and masters [and increasingly doctorate] level profession." Even Jayasuria and Dennick (2011 p.104), commenting on current medical education, highlight how "training" is often reductionist, referring solely to the acquisition and performance of clinical skills. They state "the traditional approach to learning clinical skills was often a case of 'see one, do one, teach one'". In citing Marinker (1997), Jayasuria and Dennick (2011 p.104) emphasise that "the hidden curriculum is of equal, if not greater, importance in learning clinical skills", a point clearly demonstrated by each and every client presenting with psychosexual healthcare needs. Of particular relevance to the IPM, the 'hidden curriculum', as López-Sosa and Tevar (2005) explain, and Evans (2013) concurs, includes holistic dimensions of sexuality as well as the social, political and strategic world in which sexual health care is situated. Similar to Ryle (2015), López-Sosa and Tevar (2005 p.146) open up sexuality as referring to "a fundamental dimension of the fact of being a human being, based on sex, including gender, the identities of sex and gender, sexual orientation, eroticism, affective linking, and love and reproduction." Many epistemologies, or ways of knowing how we know, concerning genders and sexualities embrace broader dimensions of the hidden curriculum which constitute the learning gained within university-sector sexual health degree programmes. The epistemologies and other hidden curricula topics are the foundations which cannot be included within shorter, more clinically-focused programmes of skills and competencies-based achievement, but are no less equally essential to holistic client/patient care (Dattilo and Brewer 2005; Evans 2011).

Undoubtedly skills and competencies training are essential elements of safe and good client/patient care, but they are also just two elements of broader approaches to care delivery in the ever-developing political, technological, digital and policy-driven age in which advanced clinical professionals live and work. Senior and specialist nursing clinicians are more often than not required to have, or be working towards, a relevant master's degree. Some consultant nurse posts are slowly moving towards professional or academic doctoral candidates, too, as predicted by this author.
earlier (RCN 2001 p.20). The language and ethos of "nurse training", ther e of re, whic h tra ditiona lly equates a ll forms of learning and education with clinical skills and competencies, is out-dated, shackling models of learning to the past, and truly missing the point of wider, holistic, approaches in contemporary philosophies of nursing set within their (new) home of higher education.

Future directions? What are the choices?
Members of the IPM rightly acknowledge that they are not alone in providing psychosexual counselling, therapy and associated education. As well as certain for Trusts to employ. Of course, the certification from similarly skilled and educated, might be less expensive for them. Many medical specialties - that other professionals, no mean feat considering natural reservations - across the Society of Sexual Health Advisers (SSHA') and the Association of PsychoSexual Nursing (APSN'), Physiotherapists, others include, but are not limited to, the College of Sexual and Relationship Therapists (COSRT'). IPM members at Conference explored options which move away from an educational silo mentality. This is no mean feat considering natural reservations - across many medical specialties - that other professionals, similarly skilled and educated, might be less expensive for Trusts to employ. Of course, the certification from the IPM does not claim to qualify one as an actual psychosexual 'therapist' or 'counsellor', but a particular healthcare professional who happens to be educated in certain theories and skills which ultimately enhance their own relevant practice, their professional registration, be this a gynaecologist, general practitioner, nurse or physiotherapist.

In essence, there are probably three main choices for IPM members to consider for future directions:
1. Carry on with the status quo - "we've always done it this way!"
2. Permit nurses to do the exact same 'training' and exam as medical practitioners, and preface their certification with "Nurse" However, a note of caution: care must be taken referring to short courses as 'diploma'; this practice is misleading to the public, professionals and employers alike. (See below for further discussion).
3. Fully integrate learning opportunities across professions and within academic frameworks that promote further joint learning and lead to significant professional/academic awards for medical and nursing practitioners.

Option 1 has obviously worked well for a long time. It is the default position of professional bodies providing a respected programme of education, training and clinical experience suitable for the progression of its members in relation to their clients' needs and their members' own professional development. Where this provision is now called for, certain examinations with registrants of allied health care and nursing are required. The sharing of learning resources, clinical experiences and conclusions, is in relation to the increasing practice of multi-professionalism. While there may be some fears. These fears may be for themselves (i.e. the profession), for patients, and occasionally for staff, that promote further joint learning and lead to significant professional/academic awards for medical and nursing practitioners.

In summary, Nurse (or Associate) Diplomate Member of - yes; Nursing Diploma of - probably no.

In exploring the third option, although, of course, no decisions have yet been made, the IPM is being pragmatic in its response, by at least considering the feasibility of sharing learning across multi-professional groups that provide similar services and outcomes in patient care. This stance is mindful of maximising shrinking resources, such as financial pressures on CPPD, and equally cognisant on ever-developing role expectations a nd competencies. If mu lti-prof essionals undertake the exact same learning and examinations as others but have the title of their certification adapted, e.g. designating a diploma as a "Nurse " diploma, then this is a concern notably regarding the meaning and extent of such a diploma.

Academic credit and validation of clinical excellence, "Academic credit ensures that [professionally-based] courses are of a comparable standard (in terms of equivalence of credit and level being awarded) to university-run courses" (University of Greenwich 2010 p.1).

Medical organisations new to considering educational courses with nurses w ill, no do ub, ha ve numerous questions and concerns. The questions and concerns are sometimes shrouded in unnecessary fears. These fears may be for themselves (i.e. the medical organisations); concemrs of burdensome
assignment workloads; of duplicate or increased fees f or st udents ( professio na l or ga nisation plus university), or of onerous f ees f or prof essional a l organisations working towards a credit rating process. There are also misunderstandings on how universities accept a nd use a c a dem ic credit tr a nsfer re quirements. Equally, from certain nursing perspectives, such fears might be coupled with an emotive use of language and personal regret over the demise of former National Nursing Boards and their respective core curricula or 'training' regimes (Mehigan et al. 2010; Mehigan 2013). As Lamont (2013) rightly points out, suc h hy perbole muddies the waters of this current debate. In clear contrast to the above fears, the British Association for Sexual Health and HIV (BASHH) is a prime example of collation for clinical and educational sharing, with its academic credit rating for part of a suite of learning initiatives provided to medical and nursing colleagues alike. Whether education is classroom based, web-based or any of these, the key issue for academic credit is that it relates both to a suitable academic level (e.g. Level 6, 'top of degree' or Level 7: postgraduate) and is sufficient in time. Usually, ten hours of learning equates to one academic credit.

"Credit rating is a part of a growing commitment to lifelong learning and professional enhancement. It recognises that a great deal of learning takes place outside the formal institutional structure of a university" (University of Greenwich 2010 p.1).

Recruitment to Psychosexual, Sexual and Reproductive Healthcare Services

Recruitment of appropriately educated staff into clinical services is a multi-layered phenomenon, outside the scope of this article. A typical barrier for nurses is when a 'essential I re qu irement' f or em ploy ment is being alleged in possession of a particular qualification, but at the same time, unable to undertake the learning without the rele vant practice-based experience: a catch-22 situation (Hadley and Evans 2013). An associated double bind for nurses equally concerns the personal demands caused by ever diminishing f unding for educational opportunities coupled with little or no study leave in which to complete it. There is an increasing expectation on nurses to self-fund courses plus undertake the learning all in one's own time. This is especially problematic across fields at practice in sexual health, including psychosexual health and well-being, which may not be considered a s the practitioner 's pr imary role or function (Evans 2011 1). An alternative example is demonstrated in the excellent model described by Shaw et al. (2013). This sort of educational provision, supported with one-off generous funding from the Department of Health, will only be possible in a minority of cases, especially given that Shaw's description of training employees are supernumerary for a set period of time. The option of combining pr ofessional work and training pr ograms, as Shaw exemplifies, arguably helps individual registrants to achieve both the specialist practice they aspire to (e.g. at Specialist Registrar I Advanced Nurse Practitioner levels) as well as consolidating education within wider, holistic, curricula aimed at higher academic I full postgraduate awards (NHS-LSHP 2012).
providers, without the award of a degree not truly being their own, but rather a collection of credits from many other sources. It must be emphasised that there is not a 'them and us' between professional organisations and institutes of higher education. BASH H has demonstrated how its 'gold standard' multi-professional clinical education programme 'maps across' to specific learning outcomes at relevant educational levels for credits to be awarded and used towards significant academic awards, enabling clinical, professional and educational development. From this win-win perspective, practice informs the curriculum, just as the curriculum validates and promotes professional clinical practice.

If the IPM decides to admit nurses and allied health professionals to its programme of learning and examination, and again, if this learning is then set within the wider framework of credits for full academic awards, such suitably qualified professionals will:

- be acknowledged by the IPM and H EIs as being professionally and academically 'fit for purpose' to advance safe practice in the psychosexual care they give to clients
- develop a portfolio of learning, skills and competencies, shared with and recognised by medical colleagues
- be able to work towards a significant academic award whilst undertaking a programme with colleagues at the IPM
- be able to access a structured and supported programme which enhances the Knowledge and Skills Framework (KSF) gateways, allowing them access to a career structure within psychosexual healthcare
- as postgraduate students: have recognition of 'the wider curriculum' learning and experiences, including research skills, and leadership and management for advanced practice.
Conclusion
This paper has explored a number of underlying concerns and issues related to the discussion about possible widening of learning opportunities, by the Institute of Psychosexual Medicine, to colleagues on different professional practice registers. The article has exposed variances not only between a d i on 1 methods and programmes of medical and nursing learning, but also between unhelpful and outmoded s y stems of learning in preparation for their profession.

If the IPM decides to widen its programme of learning to nurses and physiotherapists, this act will not make the latter two professions into replacement medical practitioners. Rather, such a move would formally acknowledge that this post-qualifying programme of learning is appropriate for sharing with other, suitably qualified, clinical professionals. The shared education, c urrently under consideration, would be equal learning for all participants irrespective of their initial registration; it would build on their different pre-qualifying professional education and enable them to advance in certain psychosexual therapeutic relations with their clients. Finally, debates over which titles are used for which qualifications have also been explored. These debates have been set within the context of wider academic awards, where various professional-based short courses or programmes of learning can attract academic credit suitable for relevant and significant postgraduate awards. Such higher awards are increasingly demanded of nursing registrants for their career pathways. The IPM is to be commended for at least considering these opportunities for their multi-professional colleagues.

This article was based on a conference presentation by the author, available at:
http://prezi.com/i6iezwpyppdf/?utm_campaign=share&utm_medium=copy&rc=exOshare

The University of Greenwich is one of the UK's leading providers of sexual health courses and programmes, with multi-professional collaborative agreements. For details on courses, the sexual health "top up" BSc(Hons) degree, MSc Advanced Practice and doctoral (PhD) research opportunities, see: http://www2.gre.ac.uk/about/schools/health/study or contact author.

References

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1 This article will focus on nurses, as the author is not qualified to speak on behalf of physiotherapists or other allied health professionals. 
2 www.psychosexualnursing.org.uk
3 www.ssha.info
4 www.cosrt.org.uk