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Key words - learning environment / educational review / role definition / negative effects

Abstract

The operating theatre as a learning environment is controlled by factors such as the activities and power of the educator, available learning opportunities, and professional drivers such as employment and regulatory body requirements. Serious educational issues around failing students and bullying need attention. This critical commentary from an educationalist's standpoint provides a contextual framework for examining this rarely studied "classroom".

Educating student ODPs: a critical commentary on the theatre experience.

This paper intends to offer a critical commentary on how student ODPs are educated in the work setting. The commentary will cover professional, legal, educational and other issues that have a direct control over how education shapes their profession. It is well known that operating department educational programmes are complex and rely heavily upon the role of the clinical educators. The clinical educator plays a vital part to strengthening the Operating Department Practice profession and life-long learning opportunities. ODP educational programmes have constantly been in development for some time now and have kept up with the maturing profession. Although many nursing and Allied Health Professionals (AHP) recognise this necessary development, medical colleagues still appear to be unclear and have difficulty appreciating the changes ODPs have undergone (British Medical Association 2009).

The demands placed on clinical educators (and others) of ODPs has been challenging as they moved from "Technician" education (Hauxwell 1984a, 1984b) through NVQ3 (Hauxwell 2000a, 2000b) and Certificate level to its current Diploma of Higher Education ranking (Hauxwell 2002).

Given there has been four major changes to their educational award within two decades, it is not surprising that the clinical setting is central to their learning. Running parallel to those

changes has been the ever-increasing desire to utilise the operating department more effectively for patient throughput. For example, the Department of Health (DH 2009) introduced a target, that patients should receive their treatment within an 18-week cycle. To achieve this, many operating department resources, are redeployed from providing staff education to support the efficient running of the operating department. Therefore it is argued that ODP clinical education faces many challenges.

What motivates teaching in the workplace?

What motivates many to teach and learn in the workplace is often their statutory regulator's requirements. The ODP regulator, the Health Professions Council (HPC) provide a professional set of standards that student ODPs work towards during their pre-registration programme. On successful completion they provide the necessary evidence for acceptance onto the registrant list. Further, for those who continue their career and become educators, they will be expected to adhere to the Standards of Education and Training (HPC 2009). For ODP educators (the chosen term for this paper), what this author considers to be at the core of practice for workplace teachers in *Standards of Education and Training* (HPC 2009) is that:

5.3 The practice placement settings must provide a safe and supportive environment.

5.8 Practice placement educators must undertake appropriate practice placement educator training.

(Page 7)

This publication relates to establishment (validation) and monitoring of educational standards, more appropriate should be what the HPC asks of qualified ODPs (HPC 2008), as they comprise part of the teaching and assessment process for student ODPs. . Generically there is no substantive reference to supporting learners; in the specific criteria there are also no references to supporting learners or participating in educational programmes in the workplace. Similarly there are none in those of any other AHPs registered with the HPC; it is not clear why this area

of regulation that has been avoided. However, the Nursing and Midwifery Council's (NMC) Code (NMC 2008) clarifies:

Work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community

By stating that:

You must facilitate students and others to develop their competence

The NMC also executes the function of defining standards for assessment and learning in practice (NMC 2006) that in the case of ODP education, is not the domain of the regulatory body, but is guided by three professional bodies/associations¹, whose work the HPC regards as “complementary” to their own role without indicating what level of collaboration is practiced (HPC,2009). For approval of courses there is guidance from the College of Operating Department Practitioners (CODP). (CODP 2006), and for those teaching and assessing in the workplace there are recently reviewed and re-issued standards, where there is some limited discussion that contributes to the notion of making the learning environment supportive (CODP 2009).

If the licensing of practice comes with registration with the HPC, and there is no clear guidance from this source, then the ODP workplace educator has only their contract of employment to follow. It is outside the scope of this paper to investigate these.

The remaining impetus is a socio-educational one – altruism – a selfless concern for the welfare of others; so, as participants in the education of adults, teachers are expected to act as role models of, amongst other traits, selflessness. Whether the individual's style of education is tightly didactic or progressive (Winch & Gingell 1999), educators must recognise the perceived hierarchy of learning and the power of knowledge, and how disadvantaged and threatened by this some learners feel at the hands of what Gopee (2008) describes as “toxic mentoring”. Gray and Smith (2000) point to how quickly learners “catch on” to their workplace teachers' personal

¹ Proprius; Association for Perioperative Practice; and CODP

characteristics as an influence on assessment outcomes. Workplace teachers of ODPs come to the role with a variety of personal learning experiences, which they may view either as a template for how they themselves will teach, or a “strategies to avoid” list for guiding their own teaching. This raises the question of how workplace educators define themselves next to the classical educational terminology of healthcare, which, so far, this paper has avoided using, but will be explored next

What defines an ODP workplace educator?

CODP uses the term “mentor” to define the person that teaches and assesses ODP students in the workplace. Gray and Smith (2000) say that the term crept into British Nursing usage from North America in the 1980s and 1990s. Quinn (2007) and Armitage and Burnard (1999) writing in the Nursing domain, agree that a mentor has a more complete involvement with a learner than a preceptor, who is engaged as a type of role model in specific clinical situations. Armitage and Burnard (1999) also ask if “supervisor” is not a more appropriate term for those who “look after” students in the workplace. Although in standard employment terminology, a supervisor is one who controls the work of qualified or experienced staff. Any decision on this nomenclature must involve an extra dimension of consideration as to whether the individual educator is a teacher or a facilitator.

Cross (1998) seems to point to educational thinkers such as Rogers (1983), who brought the term “facilitator” from the field of Psychology, in shaping a definition of teaching as being a basic mechanistic action with simple cause and effect relationship; and of facilitation as being an altogether more complex, collaborative, negotiated and highly communicative relationship. Cross also points out that some think that just the term “teacher” had gone out of fashion in the 1980s. The notion of ODP educators as facilitators is a strong one: ODP workplace educators only need to look to the assessment record that they complete for students to see that they undertake *both* types of action, in that they teach discrete skills and actions to students as well

as facilitating skills by referring students to work with particular medical and non-medical colleagues; and facilitating knowledge by referring students to policies, websites and so on. Lipp and Holmes (2009) take the concept into the operating theatre context by suggesting that acting as a facilitator for small group learning is ideal for this environment, providing time away from the intensity of clinical work and encouraging a learning culture and providing a morale booster by developing co-operation skills.

How is the defined role undertaken?

To construct a supportive learning environment the ODP workplace educator (the chosen term for this paper) must understand what factors influence learning and what the characteristics of a learning environment are. Quinn (2007) draws our attention to humanistic ideals such as understanding, approachability, inclusion and support. She goes on to cite team positiveness about learners and a good management style that values education. These attributes are displayed by those who have a serious and committed view of their educational role. This, by default, makes them a good role model, so, as such, the educator must therefore display high standards of personal conduct and appropriate attitudes to others at all times. The learner will absorb all, and copy some of what they see as allowable behaviour, so in one respect, the educator is never "off duty". Gray and Smith (2000) point to a host of negativities in the attitudes of educators to learners, evidence on the effect on the learner of observing poor attitudes between professional groups is more difficult to find (Hauxwell 2003, Gopee 2008). There is no "official line" - the HPC has already been discussed in how it defines, or rather does not define, support for learners, but it is a little more specific about personal conduct and appropriate attitudes towards other professionals in the environment.

Emotional issues are inevitable parts of a working relationship, educators need to be alert to them in their students (Quinn 2007), but also, if they are to be good role models, they need to acknowledge how their own emotions and personal problems can limit their ability to perform

the role. Therefore they need to reflect the trust that is bestowed on them by students (Gray and Smith 2000) by being honest about the fact that they are not feeling able to give their student full attention that day.

There are two serious issues that emerge from examining how the role is undertaken; one is the inability to address the issue of the failing student, the other is workplace bullying. Duffy (2004) examined the issue of student nurses passing clinical skills when not having demonstrated sufficient competence, an issue identified 10 years earlier in a paper by Lankshear (1990). Emotional, and “moral” issues related to not wanting to be the person that ends a student’s career, or the view that problems will resolve themselves later in the programme of training, were all cited as reasons for failing to fail students. Skingley et al (2007) still regard this topic as being “largely overlooked in the literature”, which is true for research on how this trait applies to ODP students.

In the case of bullying, Hume et al (2006) regard it as

still part of healthcare culture, and frequently part of the student experience (p 71)

It manifests itself in a range of activities in their study, from teasing to threats of physical violence. Educators must be hyper-sensitive to how and when they give feedback, the setting of tasks and deadlines. Essential reading for all areas in healthcare is provided by Randle (2006) who points out that without support for those who are bullied, they become double victims, seen as trouble-makers and forced to resign. Cases in breach of the terms of registration involving such actions are now coming before the HPC and can be examined on their website. Key issues about mutual respect, how learners are welcomed and spoken to, are all major considerations for the theatre unit. Educating students in a supportive environment can contain or eliminate these two issues – a strong team culture is the answer.

Team approaches to learners can both attract reluctant educators and motivate unconfident learners. An open, shared approach to ideas, instant integration of the learner, and an educational philosophy that is up to date with both the evidence-base of theatre practice and the learner's course requirements will make the environment a positive one.

Quinn (2007) discusses intrinsic factors in a supportive learning environment – students will come to a placement with varying degrees of confidence and motivation, sometimes fashioned by experiences in their previous placement. They also arrive with a set body of previous skills and knowledge which has to be taken in to account by the educator; and dependent on their age and stage in their course they raise expectations of a range of profession and life-related skills that have to be factored into the process. An assessment process that records strengths and weaknesses and shows how they are responded to provides confidence to the student (Department of Health & English National Board 2001) and an auditable demonstration to the educator of the complexity of their actual role.

How other professions are educated in theatre provides comparable and contrastable viewpoints for a consideration of the environment for ODPs. Medical students (Lyon 2003) have a system that relies on them finding their own way around the geography and society of the surgical cycle of care. This same author describes their experience as unstructured, and too heavily reliant on chance to create learning opportunities. The ODP and Nursing education systems thus stand out against this starkly as well-structured and supportive in their comprehensive design and support systems.

Where and when can theatre provide learning experiences?

The ODP pre-registration course curriculum (CODP 2006) defines opportunities for learning and core competencies; Lipp and Holmes (2009) are mainly convinced that everything that happens in theatre, whether a patient is involved or not, can be a learning opportunity. They cite overheard coffee room conversations and observing how medical staff interact as all being

important learning about how the “society” of theatre works, and what the learner’s perceptions are about power and hierarchy. Navigating the learner around these issues demands that the educator is a good role model, who neither abuses power or exploits hierarchies.

Conclusion

Although there is little research literature that deals with the ODP student and the learning environment in theatre, the expected legal guidance (from the HPC) on how a qualified ODP should support learners is not as might be expected. Contractual commitments from an employee’s point of view would benefit from further study on a national basis to find out what clauses are present in contracts of employment based on requirements that the employee should support programmes of learning in the workplace, or participate in the teaching and assessment of learners, and the link to salary banding. Likewise there is much comparative work to be done on how student Doctors, Nurses and ODPs learn in theatre. There is still a huge reliance on an altruistic approach to learning from the educator without the acknowledgement of the power that educators have over their students’ progress. The system relies on the hope that if the educator’s own experiences were good they would re-create them, and the desire that, if they were bad, they would do the opposite.

Note to Educators

This paper is a distillation of student discussions undertaken as part of the teaching process for the University of Huddersfield module - *Creating a Supportive Learning Environment in the Operating Theatre*, a module written and run for ODP mentors who seek to meet the requirements of the College of Operating Department Practitioners by holding or working towards a level 3 (HE) qualification

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