

Editorial

Practice Makes Perfect (or Does It)



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Nursing is often referred to as a practice-based discipline. For several years after the move from diploma programs based in hospitals to university-based BSN programs, schools of nursing required nurses steeped in practice to retake all of the clinical courses in BSN program—even in the clinical areas they had practiced in. Faculty believed that the only way to verify clinical knowledge and skills worthy of a college degree was to re-take the course under the better educated professor's watchful eye (preceptors did not come into use until the early 1980s). What knowledge and skills a nurse gained in practice clearly didn't seem to count—at least for 'scholarly or professional education'.

Fortunately, after a few years of experience with these RN-BSN programs some faculty innovators decided that these RN-BSN students could 'test out' of the clinical coursework and be given the credit for what they knew. In my experience at the time the 'testing out' was based on didactic content and not clinical expertise. I suspect we just didn't know how to assess clinical competence until much later. Over the ensuing decades schools have moved to accepting all clinical experiences documented in earlier nursing programs towards the BSN degree. Although the evidence about clinical competencies and assessment had begun to accumulate this evolution seemed to be based more on pragmatism a rigorous evaluation of clinical acumen and competence and expertise. I wonder why we missed an opportunity to engage in a rigorous study of what exactly clinical competence meant, what factors influenced any variability observed in students and what kinds of experiences needed to be planned during the BSN program to have all finish with somewhat equivalent outcomes.

Interestingly, until 15 years ago, in most schools, admission to graduate programs still required some number of years of 'clinical experience' in order to even be admitted to a graduate program in nursing—although the rationale for that was rarely if ever clearly articulated. One could wonder what exactly faculty thought a new graduate would gain in 3 or 5 or 7 years that would be brought to a subsequent educational program and deepen their learning. At that time (1990, 2000s) I found myself advising students to ask those questions when they were told they needed a certain number of years. [Benner's work \(1984\)](#) had heavily influenced my thinking about the journey toward clinical expertise and I wasn't one who thought 7-10 years was necessary to move on to a higher degree—but I did believe some time in practice was and welcomed the dialog than thinking about the answers to those questions. Beliefs by faculty in higher education included the perspective that what a nurse gained during the years practicing as a nurse wasn't substantive, based in research, or scholarly. That is, none of the practice time was that important and so students could 'move on' to graduate study immediately. Other faculty thought in order to learn necessary higher order skills as a graduate student practicing as a nurse was crucial in order to build on 'critical thinking, professionalism, knowledge about pathophysiologic processes, etc.'. Alas, however, in neither case did the practice experiences themselves seem to be something that was describable, generalizable or quantifiable.

For the last 10-15 years it seems we have now moved into a new phase of our beliefs and perspectives about the importance of practice to nurses moving on to graduate study. The impending wave of retirements of those in the boomer generation began to concern many. Given the above average age of graduate students in nursing compared to other fields, even a decade ago, many faculty decided that we needed younger students who were 'used to being poor', who 'hadn't set down roots for families' or who were 'used to studying'. As a result students in many undergraduate programs were strongly encouraged to continue their education without 'stopping out' for practice. Others were told to start their graduate program part-time and work at the same time. It was as if any skills learned in clinical practice as a professional nurse were irrelevant to an advanced role—especially if the roles the graduates were to assume post masters were markedly 'different' than nurses at the bedside (that is a different setting). So nursing education now has

entry level MSN programs, BSN to DNP (for APRNs as well as non-clinical majors) and BSN to PhD options. While some of these students do bring practice experience to those BSN to DNP and PhD programs, others only bring only what they learned in clinical rotations in their accelerated programs.

Now, after 10-15 years some faculty have begun to notice/observe 'differences' in students who move right on to the next degree and those who stop out to gain some practice experience. Some of these observations reflect a very positive impression of what the students bring and how they learn, develop and progress, while others hold less positive impressions and claim these students take more time to teach and learn. Are we missing another opportunity to engage in a rigorous study of these differences and examine the interface with our very structured graduate program curricula. If there are marked differences what implications might that have to altering the curricula to best fit the different student learning needs. Or does it even matter?

Read most schools of nursing websites and you will see the words, 'patient centered' patient outcomes', health outcomes, healthy environments, among other that seem to imply health and practice is at the heart of all we do, regardless of our role as researcher, educator or practitioner. Do we really believe that? Should the differing opinions faculty hold about how much, what type, and when practice counts not be a bit more evidenced-based? Complaints about variation in program types, quality and outcomes are very common at meetings where educators gather (although it is always someone else's program that is at variance). It seems to me that all of us, including our colleagues in practice, have yet to deal with the lack of definition or agreement about what counts for practice in a practice-based discipline.

The essentials, standards and actual school based requirements we have for our graduate programs related to practice learning (500-1200 hours, type of cases seen, etc.) are an attempt to standardize across programs. However, supervised hours are now rapidly becoming very precious and expensive commodities in any graduate program, as are clinical practice precepting opportunities. Are we one more time missing an opportunity to understand at a deep level through rigorous study what a student actually learns during an hour of supervised practice, how that learning may vary based on a student's previous clinical competence, and how many hours are enough or how many are too much? Is the number of 'clinical hours' mandated by accreditation and certification agencies really the only reflection of our value of 'clinical practice' competencies and expertise? What clinical experiences really shape a competent nurse after any educational program and which are dispensable and not

necessary to enter a MSN, DNP or PhD right after a BSN program. Do nurses in practice learn anything that makes them a stronger student? Does an experienced nurse bring knowledge that is valued to a cohort or just 'learn'? Or does that matter?

These very questions are not just rhetorical questions answered by opinion, personal experience or ideology. The answers could bring us closer to understanding at a deeper level what is at the heart of our practice-based discipline. Almost every nurse educator teaches the next generation of nurses, nurse scientists or nurse practitioners. What do we really mean by the term clinical practice and is it consistently important to nurses in all academic roles (ie educator, practitioner, nurse scientist) or just some of them. Do we really believe the concepts of patient-centered care, communication and teamwork, quality improvement, evidence-based practice, informatics, safety, clinical reasoning, feedback, reflection, and specialty knowledge in an area of practice (Spector, 2015) are important to every academic with the RN credential? Or are these concepts unidimensional and can be easily learned-even by those nurses with advanced degrees who never had or took the opportunity to practice?

Just exactly what do nursing credential(s) behind our names really stand for? I think there is a perfect storm of evidence about practice competencies, movement on the part of our professional associations examining assessment of competencies, and financial pressures to make sure every hour our students spend in practice is used for maximal learning. We all need to open to new ways of looking at that evidence without our own personal frames and decide what is best for our students and those nurses care for in all settings. What nurses do is far too important for us to not understand exactly what it is we do, how we learn to do what we do so we can clearly, forcefully and persuasively argue for our contributions in order to work side-by-side with other health professionals.

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