

Entering a new profession: Patient educator interns' struggles for recognition

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ABSTRACT

Objective: To ascertain patient educator interns' (PEIs) views on the internship experience and to explore how the transition to the workplace is experienced by new graduates from emergent professions.

Methods: In this case study from Saudi Arabia, semi-structured interviews were conducted with 10 PEIs. Following a narrative type of analysis, case summaries were created, compared and interpreted.

Results: Interns held preconceptions regarding the patient educator's role, and these preconceptions were frequently not mirrored by actual practice. The clash of preconceptions and actual experiences led participants to encounter shock.

Conclusion: Transition shock for PEIs seemed to be exacerbated due to their position within a new profession. This study adds to a growing literature about the challenges experienced by workers in new and emerging healthcare roles.

Keywords: New profession, patient educator, role ambiguity, role blurring, transition, transition shock

INTRODUCTION

This study aimed to explore Saudi Arabian patient educator interns' (PEIs) experiences of entering a new profession. While the World Health Organization^[1] provides formal recognition of patient educators' professional status, as does the National Commission for Health Education Credentialing^[2] and the Joint Commission International (JCI),^[3] the profession is regarded as emerging, and its level of development varies internationally.^[4] Saudi Arabia has introduced patient education in accordance with JCI accreditation guidance, and the profession is accredited at national level by the Central Board of Accreditation for Healthcare Institutions. In Saudi Arabia, patient educators are healthcare professionals who provide education to individuals in clinical settings.^[5] A patient educator's role includes but is not limited to:

- Increasing the awareness of a patient's health status, healthcare plan options and the possible consequences of these options
- Promoting decision-making
- Improving self-management, coping skills and the chances of compliance to the therapeutic regime and lifestyle changes.^[5]

The standards laid out are followed by most Saudi hospitals, leading to similar policy and role description across institutions, but variation is seen in the level of detail provided in local procedure and policy.

Professionals in other emerging healthcare professions have reported challenging experiences, such as blurring of roles, failure to be formally recognised and a desire to be accepted, but little is known about patient educators' experiences to date. Previous literature on the challenges of implementing emerging roles is summarised in three sections below, to allow comparison between patient educators and workers in other new professions.

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Formal recognition

Previous studies suggest a challenge for those in emerging professions in terms of recognition.^[6-9] New health professionals such as physician assistants,^[6] infertility counsellors,^[7] interprofessional care coordinators^[8] and music therapists^[9] have encountered challenges such as limited practice, policy and standards, workplace authority and misunderstanding from other workers in the absence of formal recognition. These studies suggest that limited formal recognition of patient education may lead to challenging circumstances for PEIs when entering new terrain.

Role ambiguity and blurring of roles

Previous studies have also indicated that workers in emerging professions encounter ambiguity with regard to their role. Lindblad *et al.*,^[10] observed that advanced practice nurses experienced difficulty conceptualising the precise nature of their roles. Further, dual diagnosis professionals identified the absence of a 'baseline' as worrying, with no previous workers in their position as examples to guide practice.^[11] This is supported by Ledger's^[9] research about music therapists who were the first to implement music therapy in their workplaces. Music therapists who were creating a new service lacked confidence in terms of practice and understanding of the role which they had gained from literature and training. Ledger^[9] indicated that the diverse possibilities for practice also contributed to ambiguity. Ambiguity was further noted in the case of interprofessional care coordinators, following movement of the role from an initially administrative function to encompassing direct care for patients.^[8]

A lack of role clarity can lead to 'role blurring' in which tasks and responsibilities overlap and the new practice is extended to involve those of different professional roles.^[12,13] Ledger^[9] and Cummings *et al.*,^[14] linked role blurring to competitive attitudes and conflicts among different professionals. For example, music therapists in Ledger's study reported that other professionals felt 'threatened' (p. 130) when music therapists tried to establish a clinical role. This was particularly the case among music therapists who worked with highly vulnerable populations, who perceived that nursing colleagues were protective of access to patients. Due to an established professionalization agenda within healthcare professions,^[15] it is unsurprising that healthcare professionals feel threatened when a new profession enters the workplace and encroaches on their role.

While the above studies presented role blurring as a challenge to new and established workers, role blurring is not always viewed negatively. In a review of literature on emerging roles in emergency care,

Hoskins^[15] described the process by which emergency nurse practitioners (ENPs) have increasingly taken on roles that were and are still carried out by junior doctors. Although ENPs could be seen to be 'encroaching on traditional medical boundaries' (p. 1899), the role has become generally accepted, with studies indicating high levels of patient satisfaction and safety. Hoskins attributed ENPs' acceptance to their ability to see the more 'unpopular' patient presentations (p. 1889), as other emerging professions have met with more resistance. This study suggested that other workers may be less threatened by role blurring when they see the new worker as lessening their own work demands.

Desire to be accepted

The desire of new professionals to be accepted is also identified in the literature.^[9,11] Ledger^[9] found isolation to be a common experience among music therapists, as well as a need to create an accepted working approach in the absence of detailed guidance. Those in other emerging roles have also felt compelled to demonstrate the value of their role and expend great effort to be accepted by other professionals.^[9,11]

For graduates in emerging professions, the above-mentioned demands may be experienced on top of the challenges which graduates of more established professions encounter. The transition from training to the workplace has previously been understood as a critical learning period^[16] which is associated with a number of challenges that can influence new graduates' personal and professional lives.^[17-19] Kramer^[20] and Duchscher^[21] reported that new nurses experienced shock as a response to the mismatch between educational and professional environments. Duchscher^[21] proposed that new nurses' transition shock includes emotional, physical, intellectual and social development elements. Contained within the emotional component is a perceived inadequacy when faced with the responsibilities of tasks and decision-making. Confidence may be weakened and anxiety increased for new entrants to a profession where complex situations are encountered, as in care of patients suffering from multiple conditions, and where a lack of preparedness in coping with situations is identified.^[19,21-24] Physical shock can stem from the challenge of heavy workload or lengthy shift work, as well as from difficulties in task prioritisation.^[19,21,24,25] Intellectual shock occurs when graduates recognise deficits in knowledge,^[21] such as unfamiliarity with working systems and roles. Shock occurs at a sociodevelopmental level where there is a mismatch between perceptions of the role while training and the role in practice,^[21,24,26] shown, for instance, in the degree to which it is acceptable to communicate opinions to staff with greater seniority.^[21]

Sociodevelopmental shock can also arise when new professionals experience limited opportunities to put into practice the knowledge or skills which they learned while studying.^[27] This last type of shock is likely to be experienced by graduates in new professions, whose role is yet to be established in healthcare environments.

Much of the published literature on newly graduated health practitioners' transitions to the workplace focuses on well-established professional roles, but there is comparatively little on newer roles and nothing concerning patient educators' transition to practice. This research is planned to address this gap, by seeking PEIs' perceptions of their time as interns and the process of moving from student to professional for them.

METHODS

Research design

This was a single embedded case study which employed qualitative methods to explore PEIs' experiences of transition to the workplace. Interviews were conducted with ten PEIs in Saudi Arabia to ascertain their views on the internship experience. Data were analysed using a narrative analysis approach and the first researcher's experience as a patient educator was used to reflect on the data.

Study sample

The choice of the case was informed by the research aim, in line with an intrinsic case study approach.^[28,29] At the year of data collection, there were 31 PEIs undergoing internship training in Saudi Arabia, who were considered as potential participants. Eighteen PEIs met the inclusion criterion of completion of a minimum of 6 months of internship. Due to the time constraints of the research, it was possible to recruit 10 of these PEIs. All participants were female, in Riyadh city and had completed a degree of health education. The internship period completed by the participants ranged from 9 to 12 months and consisted of a minimum of two and a maximum of four rotations. All participants had at least one of their rotations at a tertiary care hospital, six had rotations in specialist health centres, two went to school health units, two had been to non-governmental organisations and four to governmental organisations.

Data collection

All interviews were conducted face to face and were audio recorded. Interviews lasted between 35 and 70 min. Participants were given the option of undertaking the interview in English or Arabic, and while all selected Arabic, both languages were spoken in the interviews. Interviewees were asked

to talk about their internship experiences and were given the freedom to discuss whatever they felt most important to them. Participants described their experience in chronological order, and mostly started with the selection of training places. To provide deeper understanding of the experience, PEIs were asked for clarifications and examples. At the end of each interview, participants were asked about their views of the training and about ways training could be improved. All of the participants talked openly about their perceptions, with many taking the opportunity to complain about their internship. This openness was likely the result of the interviewer's insider status. As the interviewer (first author) had also been a PEI, participants may have felt more comfortable expressing their views than if the interviewer was someone more senior or from another healthcare profession.

Informed consent

Ethical approval was obtained from both the University of Leeds Research Ethics Committee where the research was undertaken and from the Vice Rectorate for Graduate Studies and Scientific Research at King Saud University where the participants belonged. All participants signed a consent form, and the transcripts were all anonymised.

Data analysis

Interview transcripts were analysed using Polkinghorne's^[30] approach of narrative analysis. This involved developing case summaries based on each of the transcripts. This was achieved by a process of repeatedly reading and identifying parts of the transcripts which seemed important and considering the chronological order of PEIs' stories. Case summaries were developed in first person using original transcripts, including unedited quotes as long as a paragraph. When the order of PEI's stories was considered, it was obvious that the expectations of participants mismatched the encountered reality. Inspired by the narrative structural analysis approach developed by Labov and Waletzky,^[31] four components were then identified in each summary: expectations, experiences, emotional responses and actions. This approach helped the process of analysis and facilitated comparison of the experiences providing deeper understanding.

RESULT

The interviews revealed that PEIs' internship journeys were mixed, including both negative obstacles and positive encounters. Most PEIs interviewed seemed emotionally committed and passionate about their career choice. Further, several participants seemed personally invested in their role and strongly emphasised its value;

‘we are very important, we make a difference, doctors don’t spend enough time with the patients – the educator’s role is to sit with chronic patients, talk with them, discuss the disease, the treatment, the complications and advise them on what to do’.

–Amber

These high expectations of patient educator work were not always met, and this disconnection presented an obstacle for the participants, as did issues relating to their patient educator and intern roles. Table 1 shows examples of PEIs’ experiences and the mismatch between their hopes and expectations and the reality of practice.

One challenge which emerged was poor understanding regarding the role of the patient educator as distinct from other professionals and patients. With regard to patient perceptions, one participant explained that:

‘for them you are the person that can do everything, they ask you to do the work of the social worker like asking you to get them a blood pressure monitor or so, and this is not my work, it is not my specialty at all, so I start telling them that there are certain people for that, anyway I have noticed that a lot of people here don’t know what health promotion is’.

–Sara

Similar issues also occurred with other health professionals:

‘Even staff members ask, “what do you do here? Do you just explain to patients? Doctors already do that”... you know, this is kind of degrading – nurses of course don’t accept us at all, we are on their blacklist, I sometimes hear them talking among themselves “what do health educators do?” and one may reply “they monitor blood pressure, blood sugar and stuff and if there is a referral for excessive weight gain, they talk to patients, to convince them, they also talk patients into transplants or whatever” so they accept that. When I hear that I feel devastated and disappointed and I feel tempted to explain but I can’t because they haven’t asked me directly’.

–Sara

From her account of interacting with other health professionals, the challenge facing Sara was not simply a lack of knowledge, but the antagonism she perceived from different groups.

Role uncertainty was revealed as a key issue for PEIs, as evidenced by the following quotation:

‘I told the girls that we had wasted 5 years in college, I wished I had studied something that people knew,

like radiology or laboratories, at least we would have a clear job in any hospital. It is really upsetting, people sometimes ask about our role – we actually do a lot of things; we engage in patient education, we participate in public events, we provide education to employees, there is no precise answer’.

–Jane

This quotation shows how multiple responsibilities could be a source of uncertainty for PEIs, which became apparent when others asked them what they do.

While issues in recognising the patient educator role were seen on a personal level, there was also a more formal or organisational aspect to this issue:

‘my problem is not with the individuals, it is with a community, the healthcare community underestimate patient educators, our department is oppressed, it is not being given any importance’.

–Amber

Here, Amber is referring to a lack of distinction made in comparison to other professional groups, notably by the absence of a department and role definition.

Jane reported being ‘devastated’ to discover that a patient education department did not even exist at her workplace:

‘of course one of the most upsetting things is that our department does not have a name, I mean when we asked the security about the health education, health promotion department, he said “I don’t know”... then we found it under the media department, that was devastating, you know you study and study and then when you start in the hospital you find no clear name, this is very upsetting’.

–Jane

Amber further attributed lack of recognition to ignorance of the contribution of educators in all but one clinical area:

‘They know they need diabetes educators so they value them but no attention is given to the others’.

–Amber

Notably, most participants expressed a desire to be distinguished from others who held different qualifications or worked in different and sometimes non-healthcare roles:

‘I was very, very devastated, it is devastating, it doesn’t matter whether you have a Masters, a PhD,

Table 1: The mismatch between PEIs' expectations and the reality of practice

Patient educator intern	Expectations	Experience	Emotional responses	Personal action
Amber	They (health education department) told us that we would do health promotion campaigns and community education	We worked in a shopping mall at night	The worst experiences ever, this unsuccessful experience made me depressed: Especially since I had been very excited about starting my internship training in this department	Therefore, I decided to go to another city and have a rotation in hospital J
Emma	We were supposed to educate people and give lectures	We were shocked that they wanted us for marketing	It was a successful programme, but we were in the wrong place	Practiced as directed but did not consider the period as beneficial training period
Jane	Patient educator role recognised in hospitals	Some hospitals do not really recognise us, we have no status there, the department doesn't have a status, so when you go there they don't even know who you are	You feel worthless	I told the girls that we had wasted 5 years in college, I wished I had studied something that people knew, like radiology or laboratories, at least we would have a clear job in any hospital
Sara	Staff understand the role of patient educator interns and accept them as team members	Even staff members ask, 'what do you do here? Do you just explain to patients? Doctors already do that...' you know, this is kind of degrading-nurses of course do not accept us at all, we are on their blacklist	I feel devastated and disappointed	However, as difficult as it is, it does not hold me back: Instead it motivates me to work harder to lift the name of health educators and show people who we really are
Brooke	I started my training in hospital G, which is one of the most renowned hospitals	The department was not well established	We did not like the situation	We started asking for work

a Bachelor's, a diploma, it is all the same, all under the name of health education'.

-Sara

'Honestly, there I was unbelievably devastated, I mean we were like everybody else, we were all under the name of health promotion specialists'.

-Jane

Inflexibility in regard to the role was apparent among participants. This caused them to underappreciate some of the activities they were involved in and the experience gained from them. This is shown in the following example where a PEI discussed working in health promotion campaigns:

'I personally don't like events, the preparations and everything, I like building my medical information so I like seeing patients more, this is where I feel the benefit is'.

-Ruby

Similarly another PEI did not consider the campaigns as a responsibility for patient educators, and as a result described engaging in these campaigns as being in 'the wrong place'

-Emma

DISCUSSION

The PEIs interviewed reported issues arising from mismatched expectations and actual experience of internship. Participants were passionate about their chosen field and a number of them seemed to understand how patient educators could contribute in healthcare, and had expectations of the work and training to be provided during internship based on this. As such, PEI's experiences were observed to be similar to the experiences of graduates of other new professions that are reported in previous healthcare literature.

Many PEIs in this study experienced difficulty finding connections between the role they felt that they have been prepared for and their actual role in the workplace. This phenomenon has been described by Duchscher^[21] as a sociocultural form of transition shock. In PEIs, being from a new profession seemed to magnify this form of shock and it was often linked to a lack of formal recognition of the patient educator role. Some participants reported that on arrival at their training organisations, they discovered that there was no department of patient education, that their role was undefined, or that their professional group did not have an identity as distinct from others. Feelings expressed by PEIs who encountered this scenario included disappointment and devastation. Research among other emerging professions has revealed similar experiences among, infertility counsellors,^[7]

interprofessional care coordinators,^[8] physician assistants^[6] and music therapists.^[9] The strong reactions of PEIs in this study reinforce that graduates in new professions should expect challenges when entering the workplace and consider how they will cope with challenges when they arise.

Participants' desire for their role to be formally recognised fits with previous literature, in which both practice and training is proposed to be enhanced where a professional role is accredited and formally recognised.^[6,7] In Saudi Arabia, while PEIs perceive problems in being formally recognised, there is a requirement within a number of hospitals in the country to include patient education as a part of their provision, as a quality standard required for accreditations. However, the standards set out are subject to interpretation by each hospital, and while some have laid out comprehensive processes and policy, other hospitals are yet to develop explicit role descriptions. One PEI connected the lack of formal recognition to failure of others to appreciate their value. The exception was diabetes educators, who were reported to be more often recognised as valuable. This fits with Hoskins' study^[15] in which role blurring was less of a concern when the new worker was seen to be contributing to the team. It could therefore be concluded that it is important for patient educators and their coworkers to understand the nature of patient education role and its contribution to patient care.

The lack of formal recognition was accompanied by a lack of understanding at an individual level from patients and other professionals. This is found across literature regarding emerging professions, and described as role ambiguity, which is defined as 'the lack of clear, consistent information about the behaviour expected in the role' (32, p6), and seen in advanced practice nursing,^[10] music therapy^[9] and among dual diagnosis workers.^[11] This appears to present problems for newly graduated professionals transitioning to the workplace, and particularly so where they are the first person in a workplace to fill this professional role. According to Chang and Daly,^[32] ambiguous nursing roles negatively affected new graduates through impacting on stress levels, turnover and job satisfaction. Similar difficulties were noted in the account of one particular PEI, Jane, who expressed regret in terms of her choice of career, desiring to work in a role which was understood and recognised by others. Jane's account suggests that ambiguity can greatly affect new professionals' levels of job satisfaction and possibly even cause workers to consider leaving a profession they were previously so passionate about.

Interviewees also described issues arising with different professional groups, with some sensing

interprofessional conflict. Sara's account indicated that issues arose where her role was not well understood, leading to a perception that patient educators were on nurses' 'blacklist'. Such conflicts between emerging and established professional groups have also been highlighted in research concerning music therapists^[9] and advanced practice nurses.^[10] PEIs perceived that other professionals were reluctant to work jointly with them, but equally, PEIs desired their role to be distinguished from that of others, and, in particular, wished to be viewed as separate from non-healthcare workers. Where this did not happen, strong language such as 'devastation' and 'hatred' was employed by some PEIs. It is possible that in distinguishing their work from others, PEIs lost sight of the need to work closely with others to establish a unique contribution to a specific clinical team.^[9]

Taken together, these findings suggest that although an ill-defined role for the patient educator may be off-putting to PEIs and affect their future intention to practise, inflexible perceptions of this role also hold risks of dissatisfaction. Thus, it is important to balance clear role delineation against the need for flexibility in this regard. Bridges and Meyer^[8] recognise this conflict, proposing that while clearly defining roles is essential up to a point, this must be matched by a flexible understanding which allows practitioners to tailor their role to the patient as an individual and to address staffing gaps. With reference to nursing, Chang and Daly^[32] propose that it is the role of education institutions to promote flexibility and critical thinking in their students, preparing them to cope with a range of settings. Findings from this study suggest that this is also applicable to education institutions which train patient educators. While it is certainly important to reach some clarity on the parameters of the patient educator role, it is also critical that new graduates appreciate that this role is flexible and that they should adapt to the requirements of their professional setting.

CONCLUSION

The transition from university to the workplace is a difficult period in which new graduates are prone to face a transition shock. This shock may be more severe for graduates of emerging professions such as patient education. Graduates of emerging professions not only experience the normal challenges of adjusting to the workplace but are also fighting for recognition and acceptance.

Practice implications

A lack of recognition for the role of the patient educator emerged as a challenge to those entering the profession in this study. Limited understanding of the value of the

patient educator role was identified as both a factor in PEIs' transition shock and a source of conflict with other professionals in the workplace. It is incumbent on healthcare employers and on education providers to foster greater awareness of patient education professionals. Institutions which offer degrees in health education should work to promote the identity, role and value of patient educators within healthcare to professional groups and wider society. Further, healthcare providers who employ patient educators must recognise the need to help them in establishing their role as part of wider healthcare teams and determining the tasks and activities which are most needed in their particular workplace. PEIs may also benefit from meeting a supervisor or other PEIs to gain support in establishing their roles.

While clarity and recognition of the role of patient educators is desirable, alongside this comes the need for this group to be flexible in their approach to that role. This study identified lack of flexibility as leading to a failure to engage fully with practice and learn with varied professional groups among some of the PEIs interviewed. New entrants to patient education must recognise the emerging and evolving nature of their role, and the need to be flexible in the face of varying requirements across different settings and with different patients. It is necessary for universities to encourage their students to recognise the flexible and varied nature of the role and work together with employing organisations to develop that role in practice. Promotion of role flexibility and greater collaboration between universities and workplaces may also be pertinent in a range of other emerging healthcare professions. One way of achieving greater role flexibility may be to require undergraduate students in emerging professions to complete a placement in a setting where the profession has not existed before (with long-arm supervision from a university staff member). The second author remembers this as a particularly helpful experience towards the end of her own music therapy training, when she learned the importance of listening to the needs of clients, staff, and the organisation and developing a music therapy service specific to those needs.

The findings of this study suggest that transition shock may be greater for new professional groups than the more established roles, and research could usefully be extended to other emerging professions to verify this.

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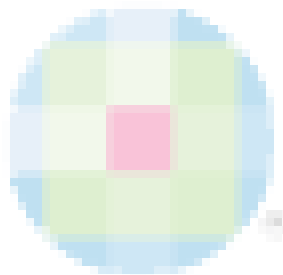
Conflicts of interest

There are no conflicts of interest.

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