

Tutorship process in health care professions: a survey investigation in Emilia Romagna

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Abstract. The areas that we wanted to investigate include: tasks performed, tools used, formalization of the assignment, workload, empowerment and satisfaction of the function performed, and training. The results clearly show that the processes of tutoring are different for physicians and non-physician healthcare professionals. The first interesting difference is the method of assignment of mentoring. While among medical professions the function is assigned by others, tutors are often non-medical volunteers. This evidence leads to two unanswered questions: what are the criteria by which they are chosen as tutors? Do volunteers really possess the skills and ability to carry out this role? Future research should be directed towards clearly defining the profile of the “tutor” among both doctors and non-medical professionals. Another difference is the way the work of the mentor is formalized. If they are doctors, the task is assigned to them; this is not the case for non-medical professions. Despite this difference, a high percentage of both medical professionals and doctors said they did not feel valued for their role of tutor. However, differences emerge: physicians see their role as a paid tutor and / or recognized in their curriculum vitae. For non-medical professions, however, the only reward is a recognition of ECM (Educazione Continua in Medicina) credits. A common feature among professionals is that for both physicians and non-physician healthcare tutors, a system of evaluation is rarely reported. Another common feature is the skills that professionals would like to see improved. Both groups of professionals, in fact, would like to see improved teaching methods, communication strategies and reporting and evaluation systems. Finally, non-physician tutors report the same level of satisfaction, although the non-physician professionals are more satisfied in their relationship with colleagues. The degree of empowerment reveals perceived differences and similarities among the professionals. In fact, both professional groups reported the same levels of competence and impact, but differ in meaning and self-determination. More specifically, the non-medical professionals show high scores, while doctors get a higher score for self-determination. These results suggest that for increased attention to the system of evaluation and enhancement of the function tutorial we need not only to increase the satisfaction of those who act as tutors, but also to improve the tutorial process itself. Furthermore, the results suggest the carrying out of training projects for teaching and assessment methods that represent the issues that are most in demand by tutors. The training should include the use of tools for the governance process that project tutorial and apprenticeships. The responses indicate that these tools are already in use, although not as widespread and continuous.

Key words: tutorship, health care professions, training, professional competences

Introduction

The student/tutor relationship, more than any other form of education, is characterized by a deep interpersonal relationship between tutor and learner. This educational relationship aims to raise awareness of one's own training in students. This aim implies a dynamic relationship where, in addition to the cognitive factor, emotional and affective factors are activated; in this case, the tutor must be a good listener and show a proactive and supporting behaviour (1).

Learning in general, and professionalizing learning in particular, is achieved by transforming the information into a knowledge network that allows learners to understand and solve problems. In this way, learning becomes a real knowledge of professional skills which can be used in organizational contexts (1). The tutor is a facilitator of learning, and he/she must make students aware of their own learning process. Accordingly, the tutorship process is characterized by the experiential nature of learning which is greatly interactive so that the educational function is expressed by accompanying the tutee to know; it is in this way that learning is realised in the mind of the learner (2).

Tutor-oriented behaviours are to accompany, to initiate, to facilitate and to support learning through an educational relationship characterized by listening, guidance and advising. In the process of tutorship, teaching and learning are the basis of the interpersonal communication between tutor and tutee (3). The attitude of the tutor must be finalized in such a way that the tutee activates his/her knowledge and ability to analyze and solve problems in a given situation and is able to independently recognize the learning needs that the situation involves (4). The growth, the autonomy and the empowerment of the person in training are the aims of the tutor model, emphasizing learning from the experience and practices of a reflective type. Practical knowledge, that constantly occurs in organizations, becomes a mediator of the learning process, opening new logics of training and stressing the importance of supportive processes for the development of professionals' skills in organizational contexts (5).

The training, then, is connected to the processes of thinking and processing, open itself to the learning experience and the promotion of contexts and opera-

tional situations where professionals act and construct their relationship with reality and their personal history (6).

Professional roles and skills are developed within organizations which need to invest resources in training activities in order to supply services (7). These training activities may take various forms, but all share a tutorial function that stems from experience and activates reflective practices. The tutor model then enters into the learning processes which focalize on the learner from the definition of the methods, timing and objectives to be achieved (1).

The tutor in healthcare settings

In a clinical setting, tutors are figures of a high educational level, who implement learning processes with a close relationship with the students, becoming an example for these students. The tutor is therefore a practitioner with a professional profile similar to that of the student; the clinical tutor guides students to the gradual acquisition of autonomy in the exercise of their profession, taking the student from a practice carried out under direct supervision to an independent professional practice (1). In this process, the tutor encourages his students to constantly reflect on their working experiences, before and after practical experience, and to consider practical experience as a part of a broader context of care. The principal behaviours of the clinical tutor should be to create a rich learning environment, to increase the acceptance and inclusion of the student, to inform and involve all operators of the student's project, to select the activities to make the students' experience consistent with the educational goals, to participate in the planning of internships, and to offer students opportunities to experience a gradual but progressive empowerment (8).

In sum, tutors contribute significantly to a) stimulating students to contextualize their scientific knowledge, b) stimulating the decision-making processes behind the action during care interventions, c) helping students to perform specific manoeuvres and to reflect on the possible mistakes.

The present research

A survey conducted in Emilia Romagna (9) highlighted the need for further study on the tutorial function in healthcare.

Following this study, the aim of this paper was twofold. Firstly, we wanted to describe the Local Health tutorial process in Emilia Romagna from the point of view of health professionals in terms of ways of recruiting tutors among professionals and of the training needs of professionals to perform the tutorial function. Furthermore, we wanted to investigate whether and how the tutorial role is formalized and evaluated and ultimately the training needs of tutors.

Secondly, we wanted to add depth to the analysis of the views of professionals about the skills which are needed for being a tutor, as well as their perceived empowerment and satisfaction. Finally, we were interested in analysing whether the above features of tutorship processes are different for nurses and physicians.

Method

Design and procedure

A cross-sectional questionnaire survey was used. Questionnaires were filled in on line and participants were rewarded with 2 ECM credits. Participants were contacted via email and invited to participate in a research study concerning the role and recognition of tutorial functions. Data were collected from September to November 2012.

Eligibility criteria

All practitioners working in the enrolled Hospitals who over the last three years had been involved in tutorship were asked to participate in the survey.

Participants

915 questionnaires were returned (response rate = 41.5%), but 117 were discarded because the profession was not indicated. The final sample was thus composed

of 798 practitioners of whom 135 (17%) were physicians, 463 were nurses (58%), 34 were physiotherapists (4.25%), 132 were laboratory technicians (16.5%) and 34 were screening technicians (4.25%). Thus, 83% of the sample represented non-physician healthcare professionals. 258 participants (32.3%) were men while 540 (67.7%) were women. 159 (19.9%) respondents were between 21 and 35 years old, 443 (55.5%) were between 36 and 50 years old and 196 (24.6%) were more than 50 years old. 40 (5%) participants had been tutors for less than one year, 300 (37.6%) participants had been tutors for one to five years, 220 (27.6%) had been tutors for six to 10 years and 238 (29.8%) had been tutors for more than ten years.

Measures

The questionnaire was composed of several parts aimed to assess different constructs.

The first part contained the following questions:

- a) How did you become a tutor?
- b) Is your work as a tutor formalized?
- c) What training did you do for the acquisition of your skills as a tutor?
- d) Is your work as a tutor valorized? How?
- e) Is your work as a tutor evaluated?
- f) What tools are you using for the management of the tutorship?
- g) What competences would you like to improve as a tutor?

The second part of the questionnaire measured the following psycho-social constructs.

Satisfaction as tutor was measured with six items - Schriesheim and Tsui (1980) (10) - asking participants to indicate their satisfaction for different aspects of their job as a tutor (i.e. relationship with coordinator, relationship with colleagues) on a 7-point Likert-type scale (1=completely unsatisfied, 7 = completely satisfied). Reliability was good ($\alpha = 0.84$).

Empowerment was measured with Spreitzer's (1995) (11) scale, which is composed of 12 items on a 7-point Likert-type scale (1=completely disagree, 7 = completely agree) and measuring four dimensions: Meaning ($\alpha = 0.93$), Competence ($\alpha = 0.86$) Self-determination ($\alpha = 0.88$) and Impact ($\alpha = 0.83$).

Results

Characteristics of tutor and tutorship

Table 1 shows percentages of responses for non-physician healthcare professions and physicians separately and for the total sample. As one can see, 153 participants (19.2%) become tutors proposing themselves voluntarily, only 43 (5.4%) are selected, 538 (67.4%) were chosen by others, while 64 (8%) indicated other ways. These percentages are significantly different for non-physician healthcare professions and physicians ($\chi^2(2) = 7.68, p = 0.02$). More precisely, physicians were more often chosen by others and less often volunteers than non-physician healthcare professionals.

The work as a tutor was declared as being formalized by 361 participants (45.2%), while it was stated as not formalized by 294 (36.8%) tutors. 143 (17.9%) tutors declared that they did not know. Also in this case, a significant difference emerged ($\chi^2(2) = 21.30, p < .001$) for which the work of physicians was more likely to be formalized than the work of non-medical practitioners.

For 63.5% of the respondents, their work as a tutor is not valorised and this percentage is equal for non-physician healthcare professions and physicians ($\chi^2(1) = 2.01, p = .16$). However, the way in which the work as tutor is valorised changes between professions. Indeed, physicians are less likely to receive ECM credits ($\chi^2(1) = 18.52, p < .001$), but more likely to receive an economic reward ($\chi^2(1) = 35.91, p < .001$) and CV acknowledgement ($\chi^2(1) = 10.40, p = .001$) than non-physician healthcare practitioners.

Moreover, the results highlight that in most cases (82.58%) professionals are not evaluated for their work as tutors. Furthermore, non-physician healthcare professionals and physicians use different tools for managing the process of tutor. More precisely, non-physician healthcare professionals are more likely to use tutorship projects ($\chi^2(1) = 40.51, p < .001$) and training contracts ($\chi^2(1) = 7.63, p = .006$) than physicians. No differences appear for other tools.

Finally, it appears that teaching, evaluation methods and relationships are the competences that professionals indicate as the more urgent competences to be improved. Also in this case, non-physician healthcare

professionals are more likely to ask for improvement in teaching methods ($\chi^2(1) = 7.08, p = .008$) or evaluation methods ($\chi^2(1) = 4.47, p = .035$) than physicians, while the latter are more likely to ask for improvement in ECM legislation ($\chi^2(1) = 5.64, p = .018$).

Satisfaction and empowerment

Table 2 shows mean and standard deviation for satisfaction and empowerment scores separately for non-physician healthcare professions and physicians as well as for the total sample. As one can see, tutors are fairly well satisfied for all the dimensions considered, apart from reward, which receives the lowest score. Only one difference appeared between professionals: physicians seem to be less satisfied than other professionals about their relationship with colleagues ($t(796) = 2.29, p = .022$).

Also empowerment was fairly good among professionals. In this case, non-physician healthcare professionals have higher scores on the "meaning" dimension ($t(796) = 2.66, p = .008$) than physicians who, however, scored higher on Self-determination ($t(796) = 3.23, p = .001$).

Conclusions

The results clearly demonstrate that tutorship processes are different for physicians and non-physician healthcare professionals. The first interesting difference is the method of allocation of tutoring. While among medical professions the function is assigned by others, in non-physician health professions tutors are often volunteers. This evidence leads to two unanswered questions: what are the criteria by which tutors are chosen? Do volunteers really have the skills and ability to perform this role? Future research should be oriented to define clearly the profile of the "tutor" among both physicians and non-physician healthcare professionals.

A further difference is the way in which tutors' jobs are formalized. Although for physicians the function is formalized, this is not the case for non-physician health care professions. Despite this difference, a high percentage of both physicians and non-physician

Table 1. Percentage of response for non-medical professions, physicians, and the total sample

	Non-medical professions		Physicians		Total	
	n	%	n	%	n	%
How you become a tutor?						
I volunteered to do tutor	138	22.62	15	12.10	153	19.2
Making a selection	37	6.07	6	4.84	43	5.4
Chosen by other	435	71.31	103	83.06	538	67.4
Other	53	8.69	11	8.87	64	8
Work as tutor formalized?						
Yes	279	42.08	82	60.74	361	45.2
No	267	40.27	27	20.00	294	36.8
Don't know	117	17.65	26	19.26	143	17.9
What training?*						
University courses	98	12.98	20	11.98	118	12.8
Hospital training	294	38.94	22	13.17	316	34.27
Regional courses	22	2.91	14	8.38	36	3.9
Professional association courses	18	2.38	18	10.78	36	3.9
None	321	42.52	93	55.69	414	44.9
Other	2	0.26	0	0	2	0.22
Work as tutor valorised?						
Yes	249	37.56	42	31.11	291	36.5
No	414	62.44	93	68.89	507	63.5
How is valorised?*						
ECM	188	59.31	18	30.51	206	54.79
Acknowledgment of hours	54	17.03	7	11.86	61	16.22
Economic Reward	12	3.79	14	23.73	26	6.91
Curriculum	59	18.61	20	33.90	79	21.01
Other	4	1.26	0	0.00	4	1.06
Is your work as tutor evaluated?						
Yes	123	18.55	16	11.85	139	17.42
No	540	81.45	119	88.15	659	82.58
Tools for manage tutorship?*						
Tutorship project	345	30.78	30	15.96	375	28.65
Training contract	91	8.12	7	3.72	98	7.49
Caring report	139	12.40	19	10.11	158	12.07
Briefing & de-briefing	131	11.69	33	17.55	164	12.53
Evaluation	392	34.97	91	48.40	483	36.90
Other	23	2.05	8	4.26	31	2.37
Competence to be improved*						
Teaching method	420	37.53	69	31.80	489	36.60
Communication and relation	283	25.29	61	28.11	344	25.75
Evaluation method	276	24.66	43	19.82	319	23.88
Hospital organization	74	6.61	20	9.22	94	7.04
University organization	22	1.97	7	3.23	29	2.17
ECM legislation	44	3.93	17	7.83	61	4.57

*more than one answer was allowed

Table 2. Mean and standard deviation of satisfaction and empowerment score among non-medical professionals and physicians and for the total sample

	Non-medical professions		Physicians		Total	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Satisfaction						
Kind of job	4.98	1.44	5.07	1.38	4.99	1.43
Relationship with coordinator/superiors	4.91	1.61	4.70	1.78	4.87	1.64
Relationship with colleagues*	5.24	1.34	4.95	1.50	5.19	1.38
Rewards	3.53	1.77	3.25	1.74	3.48	1.77
Personal development	4.21	1.94	4.46	1.75	4.25	1.91
Work as tutor	4.90	1.50	4.96	1.45	4.91	1.49
Satisfaction mean	4.63	1.21	4.56	1.19	4.62	1.20
Empowerment						
Meaning*	5.19	1.48	4.82	1.49	5.13	1.49
Competence	5.24	1.23	5.23	1.16	5.24	1.22
Self-determination*	5.22	1.38	5.63	1.14	5.29	1.35
Impact	4.88	1.30	4.88	1.40	4.88	1.31
Empowerment mean	5.13	1.15	5.14	1.10	5.13	1.14

* Difference between non-medical professionals and physicians is different at $p < .05$. Note: range of response = 1-7

healthcare professionals claimed that they do not feel appreciated for their role of tutor. However, differences also emerged in this case: physicians are more likely to be paid and/or recognized in their curriculum vitae. For non-physician healthcare professions, however, the only reward is the non-remunerative allocation of ECM credits.

A common aspect among professionals is that for both physicians and non-physician healthcare tutors a system of evaluation is seldom reported. Another shared feature is the competencies that professionals would like to see enhanced. Indeed, both groups of tutors express the need to acquire teaching methods, communication and relational strategies and evaluation systems.

Finally, non-physician healthcare professionals and physicians report the same level of satisfaction, although the non-physician healthcare professionals are more satisfied about their relationship with colleagues than physicians. Moreover, both groups of professionals report lower levels of satisfaction concerning rewards. Perceived empowerment reveals differences and similarities among the two groups of professionals. Indeed, both professional categories report the same levels of competence and impact, but differ concerning meaning and self-determination. More precisely,

non-physician healthcare professionals scored higher on meaning while physicians scored higher on self-determination.

The findings of this study suggest that greater attention to the evaluation system and enhancement of the tutorial function is necessary, not only to increase the satisfaction of those who carry out the tutorial function but also to improve the tutorial process itself. Furthermore, the results suggest the implementing of training projects for teaching and evaluation methods which represent the topics that are most requested by tutors. The training should include the use of tools for the governance process which the tutorial projects and contracts of apprenticeship training. The replies indicate that these tools are already in use, although not so widespread and continuous,

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