Mentorship, preceptorship and clinical supervision: Three key processes for supporting midwives

Authors:
Sue Lennox RN, RM, BA, MA (Applied) PhD Candidate Victoria University of Wellington
Midwife Consultant
Self employed case loading practice
Correspondence to: suelennox@xtra.co.nz

Joan Skinner RM PhD
Senior Lecturer
Graduate School of Nursing, Midwifery and Health
Victoria University of Wellington

Maralyn Foureur
Professor of Midwifery
Northern Sydney Central Coast Health and University of Technology Sydney

Abstract

New Zealand midwives are increasingly seeking and receiving professional support in clinical practice. This support is gaining acceptance within the profession and is now underpinned by government funding. There are a variety of ways in which support can be provided and this review of the literature describes three main approaches: mentoring, preceptorship and clinical supervision. These three key processes may be undertaken by all midwives whether new to practice or new to New Zealand and also by those who wish ongoing support and development. The first government funded support for all new midwifery graduates is called the Midwifery First Year of Practice programme (MFYP) (New Zealand College of Midwives, 2007). The programme commenced in 2007 and includes a mentoring component.

This paper traces the different histories of the terms: mentoring, preceptorship and clinical supervision internationally with reference to their current significance within New Zealand midwifery. These terms have evolved over time, and within different international contexts can manifest quite differently. The array of meanings ascribed to the same concept can cause confusion when midwives begin practice, change from hospital to community practice or change countries. This paper captures the common characteristics of the three terms in the literature. Clarity around the terms is essential if midwives are to gain maximum benefit from the provision of funded support for clinical practice.

Introduction

New Zealand midwives are increasingly seeking and receiving professional support in practice and there are a variety of ways in which this support can be provided. In this paper we focus in particular on the three most common forms: mentoring, preceptoring and clinical supervision. Each of these three processes has different historical roots. For example, Homer wrote in The Odyssey about mentoring which was an ancient Greek practice where older men voluntarily encouraged and supported younger men (Homer, 1945). The term 'preceptorship' originated within religious practices in the 15th and 16th centuries in Europe but re-emerged in nursing in the 1960s in the United States of America to describe the teaching of nurses within a clinical environment (Myrick & Yonge, 2004). The term 'clinical supervision' grew out of the practice of 'supervision' which was first used in the seventeenth century for controlling apothecaries by providing paid advice to them by the emerging, elite, medical class (Grauel, 2002). In this paper we explore these three common terms in an attempt to outline the general features which distinguish them and why their meanings are sometimes confused. Elaborating on the evolution of all three terms with a particular focus on mentoring can provide New Zealand midwives with an understanding of the history and intention of professionally supportive relationships, both for those giving and receiving such support.

Various beliefs coalesce around the terms mentoring, preceptoring and supervision which affect the sorts of support provided by mentors, preceptors and clinical supervisors. Shared understandings within the profession of the commonly held assumptions underlying these support terms could encourage more consistent standards of support. Table 1 summarises the most commonly held assumptions about each of the terms found in the literature – though contrary examples exist for each of the categories. In this article we review each of the terms according to their origins and evolution and look at their most commonly described characteristics such as duration of support, how the relationship is framed and who determines when the support relationship ends.

Mentoring

There are three types of mentoring most commonly described in the literature. Understanding the distinctions made between these types helps not only to clarify mentoring but also illuminates the ways in which mentoring differs from other forms of support.

The first, 'classical mentoring' has its historical and conceptual roots in Homer's Odyssey. Some twenty years after baby Telemarchus was left by his father under the care of Mentor, the Goddess Athena visited the young adult Telemarchus in order to 'embolden him' (Homer, 1945 p.23). She comes disguised as a local to gain admission to his home and provides guidance for him as a voluntary act of kindness and goodwill. These qualities of voluntariness, kindness and goodwill hold the key to the informal type of mentoring, called 'classical mentoring'.

The second type of mentoring is 'institutional' or 'business mentoring' which began in the 1970s and is a phenomenon commonly associated with corporations (Hagerty, 1986). This first began as a form of career support within the business world in the United States of America. The informal classical conception of the mentor prototype as a guardian or a personal helper for a less experienced colleague became incorporated into business practice. One example is characterised in the support provided to Richard Branson by Freddie Laker (Levinson, Darrow, Klein, Levinson, & McKee, 1978). This type of mentoring is characterised by grooming new and talented employees for career advancement. Evidence showed those who were singled out and given personal support did indeed flourish (Kram, 1983; Levinson, Darrow, Klein, Levinson, & McKee, 1978). The effectiveness of the idea of providing individual support for career transitions was developed as a generalised professional support term outside the business world.

The third type of mentoring called 'formal mentoring' is characterised by the mentoring component of New Zealand's government funded Midwifery First Year of Practice programme (MFYP) (New Zealand College of Midwives, 2007). This formal model encourages the qualities of classical mentoring in that the new graduates choose their own mentor. However the MFYP also has formal specifications in that mentors have to opt onto the programme and to attend training workshops as well as monitoring the number and hours of contact time. This is a structured process where the focus is on planned goals and expectations. There is evidence that formal mentoring programmes are more effective than informal or 'classical' mentoring relationships (Clutterbuck, 2001).

Mentoring began appearing in the nursing literature as early as 1977 when Vance systematically defined the mentor concept for the nursing profession (Vance, 1991). In the 1980s a nurse consultant in leadership and organisational development interviewed 150 people of whom 50 were nurses, and found that for all those studied; the essential components of "an important major mentor relationship" are attraction, action and affect which correspond to mentoring roles as inspirer, investor and supporter (Darling, 1984 p.42). Informal mentoring began to appear in the UK in the 1980s but attempts to grapple with defining the concepts and roles did not appear until the 1990s when there was a burgeoning of nursing publications about

the subject (Andrews & Wallis, 1999; Anforth, 1992; Armitage & Burnard, 1991; Donovan, 1990). The idea of mentoring was attractive to health professionals because of a focus on the learner's needs.

Mentoring captured the imagination of nurses (which included midwives) internationally. The dialogue about mentoring was vigorously argued using the adult education rhetoric. Educational theory had shifted in the recent decades from a pedagogical approach of teacher being the driver of learning to one where the student became responsible for their learning. This approach was based on changing theories about adult learning. This focus on the individual student learner also paralleled a shift from task orientated nursing practice to more person-centred patient care. The initial debate focused around the difficulties of students choosing a mentor, the need for a clear understanding about what being a mentor entailed and whether assessment would be a feature when the role was clearly about befriending, assisting and guiding (Anforth, 1992; Armitage & Burnard, 1991).

The emergence of and debates about mentoring in New Zealand were stimulated by midwifery autonomy in New Zealand (Holland, 2001). The 1992 newly convened Maternity Access Agreement Committee (MAAC) which replaced the Obstetric Standards Review Committee (OSRC) of the Auckland Area Health Board had concerns about the competency of newly graduated midwives emerging from the newly established direct entry programmes of a newly autonomous profession (Holland, 2001; Kensington, 2005). The term 'direct entry' refers to the separation of midwifery from nursing. Instead of a postgraduate nursing qualification 'Midwifery' became recognised under the law as a profession in its own right. Midwifery registration was now based on successful completion of a bachelor's degree in midwifery. The first direct entry programme commenced in Dunedin in 1992 and the first new graduates qualified at the end of 1994 (Pairman, 2006). Hospital obstetrical committees in Dunedin and Lower Hutt as well as Auckland were concerned that graduates from these courses might not be safe and made oversight by another experienced midwife-mentor a mandatory requirement before issuing access agreements to new graduate midwives (Kensington, 2005, 2006). Experienced midwives rose to the challenge voluntarily and mentored new graduate midwives. The professional body of the New Zealand College of Midwives responded with a consensus statement in 1996 which supported mentoring as an appropriate professional activity and with minor changes this statement still remains current (New Zealand College of Midwives, 2000). Processes of support and recompense were individually negotiated around the country.

From 2007 mentoring of new graduate midwives has changed from an informal relationship negotiated by the mentor and mentee to a funded and formally contracted relationship. However within this formal model strong voluntary and generous aspects of classical mentoring were retained where: "…the relationship is focussed on individual needs and maintained by self selection of the mentor and mentee" (Palmer, 2000 p.85). Having the mentees select their mentors is an important part of any mentoring arrangement whether formal or informal, since a successful relationship requires a dynamic mutuality (Morton-Cooper & Palmer, 2005). Ensuring that the individual with the primary learning need is the active part of the relationship is important if a sense of security and ease is to exist within the mentoring relationship.

Appreciating, supporting and enabling the learner to function as the active partner arose out of changes in educational theory about how adults learn best. The development of the concept of adult learning emerged from the work of Knowles (1973). His adult learning theory is based on four assumptions which differ from theories about how children learn and what had been until then the standard understanding about how learners learn. He believes adult learning is based on: changes in self-concept, the role of experience, readiness to learn and orientation to learning (Knowles, 1973). Research has also confirmed that the adult learner knows what and who they need to support their learning (Clutterbuck, 2001). This change in understanding about teachers and learners has crucial implications for mentoring. Clutterbuck found that "the relationships that worked best and most often were generally those where the mentees themselves selected their mentors" (Clutterbuck, 2001 p.27). Adult learning principles encourage the learner to take responsibility for their own learning by actively pursuing their own answers by critical reflection and problem solving (Morton-Cooper & Palmer, 2000). The mentor is framed as the conscious, experienced and professional supporter who listens, expands and supports learning.

Integral to mentoring is the notion of confidence-building by the mentor rather than competence assessment. The mentor though has a responsibility within this encounter to challenge and critique the thoughts and actions of the mentee, but in a way which enables rather than disables the new graduate's confidence (Morton-Cooper & Palmer, 2000; Surtees, 2008).

The clinical component of mentoring is subsumed within "a closer and more personal relationship" between a mentor and mentee (Armitage & Burnard, 1991; Levinson, Darrow, Klein, Levinson, & McKee, 1978; Morle, 1990). Though both mentor and mentee may gain satisfaction from the partnership, the intention of the relationship is primarily to support the mentee's interests. These interests mean that the mentee is in general the more active member, choosing the mentor, negotiating a relationship that suits her needs and taking responsibility for her own learning.

The relationship needs time to achieve the objectives of a mentoring relationship. Mentorships are generally considered long term relationships; times vary but they are generally assumed to be a year if not longer (Andrews & Wallis, 1999; Armitage & Burnard, 1991; Firtko, Stewart, & Knox, 2005; Morton-Cooper & Palmer, 2005; Shaw, 2007).

There are very few research studies about mentoring of midwives in general but even fewer about mentoring new graduate midwives. In New Zealand there are two research studies about mentoring in midwifery. Kensington (2005) focused on nine new graduates reflecting on their experiences of mentoring and of their first year of practice and Stewart & Wootton, (2005) surveyed all registered midwives for their views on mentoring. The findings from both studies showed a great variety of beliefs about both what constitutes mentoring and also about the vastly different range of support those new graduates actually needed from their mentors.

Kensington (2005) interviewed nine new graduates. These in-depth interviews exposed wide variations in the new graduate midwives' felt needs for mentoring. Five of the nine new graduates and their mentors were within the same practice and mentors were available 24 hours a day, seven days a week. Another three new graduates chose their mentors from outside of their practice with one having minimal contact with her mentor "twice for about an hour" and "talked on the phone about five or six times" in the year (Kensington, 2005 p.109). Another new graduate chose not to have a named mentor and instead joined an established practice. The transition from student to autonomous midwife practitioner was shown through the new graduates' stories. This was achieved through their mentors, "supporting and investing time into the relationship and offering advice and strategies to the mentored person" (Kensington, 2005 p.85). This occurred both on the job, in practice and, for some, later during times set aside for reflection.

The range of activities that have been associated with mentoring in midwifery causes confusion around the question of what constitutes mentoring – is it about reflection on experiences or might it also involve clinical support as well as many other teaching moments? However, this confusion is based on thinking mentorship is about what mentors 'do' rather

than how mentors are 'being' in their role. Just as the job of a midwife is to 'be responsive' to the woman's concerns and interests, the job of a mentor is to put the mentees' interest in the foreground of the relationship. The ability to both negotiate and be responsive to the mentees' needs and concerns is the work of mentoring and parallels our role with childbearing clients.

At the time of Stewart and Wootton's, (2005) New Zealand study, mentoring of new graduate midwives could be regarded as 'ad hoc'. Their descriptive survey of 684 or 44 percent of New Zealand's registered midwives questioned the understandings of practising midwives about the concept of mentoring. The results of their survey show the barriers to being a mentor were "time constraints and financial obligations" (p. 41) which resulted from midwives offering and providing time for both clinical support and for reflection about the new graduates' experience. Their solution was to suggest; "…if midwives receive clinical support from the midwives they work with in every day practice, the mentor can concentrate on providing opportunities for reflection and development away from the clinical environment…" (Stewart & Wootton, 2005, p. 41).

Financial support is now forthcoming within the MFYP programme which commenced in 2007 following the Minister of Health's 2006 announcement of funding for a pilot Midwifery First Year of Practice programme (Ministry of Health, 2007). The mentoring associated with MFYP fits closely with a formally structured model of mentoring with regulations, a professional framework, mentor training and monitoring. This model differs in quite concrete ways from preceptorship by being designed to meet the mentees' needs and purposes rather than those of the institutions in which midwives may be employed. Mentoring in general is characterised by being a voluntary long term commitment relationship supporting the learner through a professional transition and maintained through mutual and negotiated consent. The next section of this paper explores the differences and similarities between the professional support terms 'preceptorship' and 'clinical supervision' in relation to mentoring.

Preceptorship

Preceptorship is somewhat easier to differentiate from both mentoring and clinical supervision because it is framed within a hospital setting and is instituted for specific purposes and periods of time. In New Zealand nursing and midwifery became separate professions when in 1990 the Nurses Act was amended (New Zealand Statute, 1990). The separation was completed in 2004 when the Health Practitioners Competency Assurance Act established the New Zealand Midwifery Council (New Zealand Statute, 2003). However the influences of the professions' shared histories has profoundly shaped the expectations, understandings and provision of support for midwifery practitioners until very recently and much of the literature related to preceptorship in nursing refers also to midwifery.

Nurses and midwives are now educated in institutions of higher learning but up until the late twentieth century they trained and worked predominantly in hospitals. The history and emergence of preceptorship can be traced to Florence Nightingale who wrote in 1882 that first year nurses' "…practical and technical education [needs to] be supported by nurses who [have] been 'trained to train'" (cited in Palmer, 1983, p.17). Preceptorship arose out of the need to teach junior or newly engaged staff the conventions and processes of that particular hospital. This apprenticeship-style of support favoured the hospitals' needs rather than the educational needs of individual nurses (Myrick, 1988). As the education of nurses changed from hospital based training to educational institutes of higher learning, so too did the needs of the transitioning students when they entered the hospital workforce.

Nursing education in the USA was transferred from a hospital base into a variety of academic pathways to registration from the 1960s (Greenwood, 2000; Myrick, 1988). These changes to a more theoretically based nursing education occurred in New Zealand in 1973 and in Australia over a period from 1984-1993 and similarly over a period of time in the UK beginning in 1989 and completed by 2000 at the same time as Canada (Greenwood, 2000; Reid, 1994).

This change in education and practice experience for undergraduates exacerbated the sense of what Kramer (1974) called 'reality shock' for new graduates. New staff nurses who were unused to hospital practice were shocked by the experience of everyday hospital reality on entering the profession in their first year of practice. The experience of reality shock is still felt by new graduate nurses and midwives thirty years later (Cowin & Hengstberger-Sims, 2006; Kensington, 2005). The need for support for new graduates has always been present but even more so once nurses and midwives were educated outside of hospitals and on graduation needed socialisation into hospitals and their processes.

The concept of preceptorship is clearer than that of mentoring and there is little international confusion over the meaning of the term. According to the author of a recent New Zealand study (Turner, 2007) the concept of preceptorship in New Zealand is similar to that found in Australia, North America and the United Kingdom.

An Australian midwife, McKenna (2003) writes "unlike mentoring, preceptorships are primarily clinical teaching roles that are used to support the transition of mentees and graduates into new clinical environments" (p. 8). In relation to midwifery in the UK, Hobbs (2003) supports McKenna's view that preceptors "should focus upon both socialisation and the clinical development of the preceptee" (p. 6). Though Turner (2007) argues that preceptees should be able to choose their preceptor as happens in mentoring, in practice this would be unusual. Midwife preceptors unlike mentors are often appointed by a ward co-ordinator who attempts to match the pairs appropriately (Cooper, Stainsby, & Andrzejowsha, 2000).

Preceptorships tend to be of short duration from a few weeks or three to six months (Ashton & Richardson, 1992; Firtko, 2005). The length of support varies but some evidence points to the first three months as critical for successful skill acquisition and commitment to continue nursing (Dufault, 1990). The same time frame seems also to have been borne out in preceptorship in midwifery (Kensington, 2005). The relationship generally has either a predetermined length or associated with the preceptee fulfilling pre-set assessed criteria.

In summary, preceptorship is unlike mentorship in a number of significant ways: the support is for shorter periods of time, the preceptors are selected by senior nurses or midwives and not by the preceptee, and the purposes are in general predetermined by the institution which focuses on what needs to be learned rather than on the learner's needs.

Clinical Supervision

'Supervision' cannot be as easily categorised as preceptorship. It may be an institutional 'support' system which is imposed unasked, or a private support relationship which provides access to individual self governance (Fowler & Chevannes, 1998; Wickham, 2005). The latter relationship, sometimes called clinical supervision, "is complementary to, yet separate from, other forms of supervision" (Winstanley, 2000 p.31). Burrow warns us about confusing managerial supervision with clinical supervision (Burrow, 1995). Managerial supervision is primarily concerned with the needs of the institution and cannot logically prioritise individual supervisee's needs above those of an employer. What follows is a discussion about the emergence of the idea of clinical supervision from the umbrella term, 'supervision', a term which encompasses a collection of different purposes.

The history and meaning of the broad concept of supervision changes with each telling but for Grauel (2002) the pre-history emerged in the 17th and 18th Centuries within medicine in England. This use of the term 'supervision' was about power and control of one group over another's practice. However the term also has other connotations. Kelly et al (2001) describe 'supervision' as a 'bi-polar' issue because the term describes practices that are at one end enabling,

educative and encouraging and at the other end describes practices that are predominantly about controlling and assessing practitioners (Cutcliffe, Butterworth, & Proctor, 2001; Kelly, Long, & McKenna, 2001). The term has a history of clinical practice surveillance and assessment with instances of misuse of power which cast a shadow over its general understanding. The historical and theoretical foundations for mentoring are far less burdened than those of supervision and as a result the practice of clinical supervision remains confused with so many competing forms.

In Britain, regulations which included supervision of midwives have been mandated since 1902 (Day-Stirk, 2002) and supervision of midwives has served an overtly disciplinary function. Now, more than a century after the regulation was put in place, supervision is becoming more enabling (Osbourne, 2007; Winship, 1996) but some midwives in the UK still distrust the process and remain sceptical of supervision and supervisors (Osbourne, 2007). Kirkham (2000) describes a unit where both statutory supervision and clinical supervision were practised side by side and midwives viewed clinical supervision "very positively" (Kirkham & Stapleton, 2000 p.470). Research by Deery (2005) explored the views of midwives within clinical practice in the UK about their view of their support needs and how they would like these needs addressed. The midwives identified clinical supervision as a potential support for working with the complex changes within their practices (Deery, 2005).

There are many models and definitions of clinical supervision. Proctor's three-function model has consistently provided an easily understood interactive model (Proctor, 1986). The components of the model are a useful guide for both supervisor and supervisee. Clinical supervision according to Proctor should serve three categories of functions: normative (organisational responsibility, quality control), formative (development of skills and knowledge) and restorative (supporting personal well-being). Later models have explored the means by which these functions are facilitated. For example Bond and Holland have shown how the normative function (quality, standards and accountability) might be enhanced by using the restorative and formative functions within the context of clinical supervision (Bond & Holland, 1998). In Proctor's model there is an assumption of an enabling and cooperative relationship which has no formal assessment or managerial function (Morton-Cooper & Palmer, 2005). The functions outlined in this model fit the aims of the mentoring component of the New Zealand MYFP programme.

The University of Manchester can lay claim to raising the value of clinical supervision in community nursing in 1988 (Butterworth, Faugier, & Burnard, 1998) when researchers used Proctor's functions model as one of three models in developing the Manchester Clinical Supervision scale, a validated assessment tool for research on clinical supervision (Winstanley, 2000). The scale

Table 1: Broad differences between mentoring, precepting and clinical supervision

	Mentoring	Preceptoring	Clinical Supervision
Duration	Long term commitment (Andrews & Wallis, 1999; Armitage & Burnard, 1991; Firtko et al, 2005)	Short term commitment (Firtko et al, 2005)	Variable and dependent on supervisee. Tends to be ongoing.
Choice of supporter	Mentee chooses mentor A voluntary relationship between registered professionals where the inexperienced or novice practitioner chooses the experienced practitioner as an appropriate guide through a process of attaining confidence.	Preceptor appointed not chosen Preceptorship differs conceptually from mentoring particularly in regard to the preceptor being allocated to, rather than chosen by, the new graduate.	Chosen in independent supervision: a relationship which has no formal assessment or managerial oversight. (Other types of 'supervision' differ)
Purpose	Enable or develop professional confidence A mentoring relationship is one of supporting professional transition through new environments and/or experiences. This relationship may not be established or maintained by an employer.	Fitness to practice; clinical development The preceptor role is described differently to mentoring focusing on the content to be covered rather than on the new graduate's experience of practice.	Process of reflective self assessment may include both high support and high challenge (Johns & Freshwater, 1998)
Beginning	Negotiated between the parties	Ascribed	Negotiated
Ending	By mutual and negotiated consent	When term of preceptorship finishes, may be one or two weeks up to a couple of months	Ends when supervisee decides
Reason for Govt support	Response to workforce concerns both at the recruitment and the retention ends. Transition to practice is one of the key concepts attached to mentoring (Passant, 2002; Theobald, 2002).	Response to reality shock in UK and US. Support transition; role mastery and socialisation	Change from task orientation to nursing process and professional governance

has the largest data set on clinical supervision and shows that "effective clinical supervision can contribute to an improvement in skills, encouragement of reflective practice and an increase in job satisfaction" (Winstanley, 2000 p.32). The scale was used in a trial that was specifically designed to measure the effectiveness of clinical supervision on supervisees, supervisors and the quality of the care they provided. The results showed that "clinical supervision was experienced as useful and was perceived as a benefit to improve practice" (Cutcliffe et al 2001, p. 122). Evidence showed that at the very least clinical supervision operates as a means for safeguarding minimum clinical standards and at best sustains and develops excellence in practice (Bishop, 2007, 2008; Carson, 2007). Major research findings about clinical supervision for UK midwives, nurses and health visitors showed that meeting monthly for at least one hour was best and the recipients reported improvements in their care, skill and job satisfaction (Hrykas, 2001; Winstanley, 2000). Unlike mentoring, clinical supervision is well researched and comes highly recommended for use in improving the quality of clinical practice.

Anecdotally there are an increasing number of self employed midwives accessing clinical supervision in New Zealand. Clinical supervision may be funded for members of staff within hospitals but self employed Lead Maternity Carer (LMC) midwives pay as they would for other private services. Clinical supervision within midwifery is not legislated or regulated and so long as that situation remains the case the choice remains in the hands of the practitioner to commence and cease attending sessions.

There seems little difference between the values, functions and practices in independent clinical supervision and those encouraged in mentoring. In time perhaps the theoretical frameworks for both will merge and the historical differences may be left behind, along with the confusion which surrounds the terms. This confusion is as a result of the historical development of professional support and the dynamic ways in which terms change over time and within different contexts. Preceptorship has far more clarity than either of the other terms and serves an important function within hospital settings. There can be little basis for confusion between preceptoring and the other two terms, mentoring and clinical supervision. The differences in purpose and process between preceptorship and either mentorship or clinical supervision are quite marked.

Conclusion

There will always be a need for professional support in the clinical environment. The naming and understanding of the breadth and depth of the function of mentoring, precepting and supervision are important. The important issue is one of clarifying the concept attached to the roles before they become part of any system of professional support. This has been done in New Zealand with the publication of the mentoring framework (Gray, 2006). This framework outlines the New Zealand College of Midwives' concept of mentoring for the whole of the midwifery profession at any stage of a midwife's career. The formal mentoring pilot programme funded by the Clinical Training Agency arm of the Ministry of Health is focused on professional role development of the new graduate midwife and managing the formal aspects of the mentoring partnership.

Internationally terms, titles and concepts vary in their definitions and understandings 'on the ground' and this is an important feature of trying to make sense of these three terms. Many commentators agree that there is a bit of preceptoring in mentoring and vice versa and a bit of clinical supervision or reflective self development in the practice of both mentoring and preceptorship. Mentoring, preceptorship and clinical supervision despite historically different beginnings share some common features and acknowledge, at least in theory, adult learning principles. These principles support the learner's process and acknowledge the individual as the active partner in the relationship. Preceptorship has some fundamental differences based on the active partner being the preceptor with a focus on the content to be taught rather than the needs of the learner. What is important is that we have some notion of the history and concept development attached to the terms mentoring, preceptorship and clinical supervision. Eliminating confusion may benefit both nursing and midwifery practices.

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