The clinical role of nurse lecturers: Past, present, and future

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Summary  The clinical role of nurse lecturers has been the subject of much debate since the transfer of nurse education into Higher Education Institutions within the United Kingdom.

This article provides a critical evaluation of the clinical role of nurse lecturers in terms of policy drivers and strategies for implementing national guidelines. Policies from the initiation of Project 2000, through to recent consultation documents on the support of students in practice, are evaluated.

Formal aspects of the nurse lecturer remit, such as link tutor and personal supervisor roles, are discussed in terms of their impact on clinical practice. There is also a brief review of the development of the lecturer practitioner role as a bridge between education and practice.

The fundamental arguments in support of nurse lecturers maintaining a clinical role in practice are analysed. This analysis includes consideration of the concept of 'clinical credibility' in terms of the impact on teaching and the closure of the theory-practice gap.

The article concludes with suggestions for strategies to resolve the ongoing debate surrounding the clinical role of nurse lecturers. These recommendations include a review of staff:student ratios in nurse education, re-evaluation of the need for a clinical role, and the use of innovative recruitment and development strategies by higher education institutions.

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Introduction

Within the United Kingdom (UK), the transfer of nursing educational programmes into Higher Education Institutions (HEIs) in the 1990s has sparked
considerable debate surrounding the clinical role of nurse lecturers (Fisher, 2005; Kenny, 2003).

Successive governments and professional bodies have fuelled this debate by producing policy documents stressing the importance of nurse lecturers maintaining their clinical role (Fisher, 2005). In response to this, HEIs and individual lecturers have sought to develop strategies through which links with clinical practice can be maintained whilst also allowing time for teaching, research and other scholarly activity.

This article critically evaluates the clinical role of nurse lecturers. National policy surrounding this issue is evaluated, as are strategies for implementing policy requirements. For the purpose of this article, the term 'nurse lecturer' refers to educators employed solely by a HEI to provide support for pre- and post-registration nurse education programmes.

The arguments underpinning the call for a stronger clinical role for nurse lecturers and the perceived importance of 'clinical credibility' will be explored. The discussion focuses on lecturers teaching on pre-registration nursing programmes, though some reference is also made to the specific characteristics and needs of post-registration students.

The policy perspective

In the mid-1980s, a major review of the pre-registration education of nurses, midwives, and health visitors took place (United Kingdom Central Council (UKCC), 1986). As part of this review, responsibilities for the provision of teaching in the classroom and clinical areas were revised. Following an earlier reorganisation of pre-registration nurse training in the 1960s, nurse tutors provided formal classroom teaching, with students given practical tuition on placement by clinical teachers (National Health Service (NHS) Executive, 1997). The Project 2000 programme for pre-registration nursing removed the nurse tutor/clinical teacher split and instead proposed a single grade of teacher, supported by clinical mentors in practice areas (UKCC, 1986).

The new 'multi-purpose' nurse educators were to have responsibility for classroom teaching, ensuring high educational standards in practice, and supporting students on placement (UKCC, 1986). The importance of an explicit clinical role for nurse educators was highlighted in a standard statement for higher education nursing programmes insisting that lecturers should be involved in clinical practice for the equivalent of one day per week (English Nursing Board (ENB), 1997).

The transfer of nurse education into HEIs in the 1990s provided nurse lecturers with an additional challenge. Within academia, it is indicators such as publication, research activity, and grant income — not participation in practice — that provide confirmation of effective performance (Topping, 2004; Ferguson et al., 2003). This additional workload has restricted the clinical role of nurse lecturers, as has the physical separation between the educational and clinical settings (Gidman, 2001; Clifford, 1999).

In response to concerns about the clinical competence of students completing Project 2000 programmes, 'Making a Difference' (Department of Health (DH), 1999) and 'Fitness for Practice' (UKCC, 1999) provided the catalyst for the development of a new pre-registration curriculum. Within these documents, it was suggested that nurse lecturers should have recent and practical nursing experience (DH, 1999) and demonstrate clinical confidence and competence, which could be maintained by spending time in practice (UKCC, 1999). The importance of links between education and practice were further reinforced by a recent consultation document on the support of learning and assessment in clinical areas, in which it is recommended that nurse lecturers have protected time to provide clinical teaching in practice and offer support to students on placement (Nursing and Midwifery Council (NMC) 2004).

The message from successive governments and professional bodies, from Project 2000 to the present day, is clear — it is essential that nurse lecturers engage with clinical areas to maintain their skills and provide a link between education and practice (Bentley and Pegram, 2003). Despite these policy drivers, the clinical role of lecturers in practice remains poorly defined, with conflict reported between clinical responsibilities and other aspects of the role (Gilmore, 1999). In response, HEIs and individual lecturers have attempted to reconcile this conflict and establish a formal role within clinical practice.

Implementation of policy

The most commonly used method for formalising the clinical role of nurse lecturers is the 'link tutor' role (Day et al., 1998). This role was developed at the time of Project 2000 training, and gave nurse lecturers responsibility for supporting learning in a number of clinical areas (Ramage, 2004). The activities inherent within the link tutor role vary, but can include the completion of educational audits, visiting and supporting students on
placements, working clinical shifts, and carrying out clinical assessments of students (Duffy and Watson, 2001; Gilmore, 1999; Carlisle et al., 1997).

Though intended to maintain links between theory and practice, a number of studies have identified factors that limit the success of the link tutor role. Notably, a lack of role definition causes confusion and stress amongst individual lecturers regarding expectations (Gilmore, 1999; Clifford, 1999). Difficulties in carrying out link tutor duties are exacerbated by the limited time available to lecturers due to competing demands. (Pegram and Robinson, 2002; Landers, 2000; Murphy, 2000).

More worryingly, many lecturers report that resistance by clinical nurses themselves inhibits their role in practice settings. Ramage (2004) reported that lecturers often felt vulnerable, unwelcome, and even excluded, when attempting to access clinical practice, a finding that supported similar conclusions by other authors (Landers, 2000; Carlisle et al., 1997). Humphreys et al. (2000) argue that one of the prerequisites of an effective link tutor role is that lecturers are assigned areas that reflect their clinical expertise. It is possible that the feeling of being uncomfortable in practice is therefore exacerbated by the fact that the allocation of link areas is often dependent purely on organisational requirements (Clifford, 1999).

Because of difficulties inherent with the link tutor role, a number of HEIs have developed the role of personal supervisor to enhance the clinical remit of lecturers. Personal supervisors take responsibility for a small group of students throughout the entire course (Gidman, 2001). Though the role is predominantly a pastoral one, some models also require the personal supervisor to act as clinical teacher and assessor during practice placements (Humphreys et al., 2000). The personal supervisor model allows the development of close links between the lecturer and their students. However, the geographical and clinical diversity of placements means that teaching and assessing all personal students on placement is logistically difficult (Gidman, 2001).

The challenge of ensuring a clinical role for nurse lecturers has resulted in the development of jobs with formal responsibilities in both HEIs and practice. The most common of these is the lecturer practitioner. Lecturer practitioner (LP) posts were first introduced in the 1980s to provide a bridge between academia and practice (NHS Executive, 1997). As the name suggests, LPs usually split their commitments between the HEI and clinical practice in a 50:50 ratio, thereby providing a clinically skilled practitioner with strong academic ties (Pegram and Robinson, 2002).

Though this role is now widely established, there is little consensus on what LPs do, and whether they meet their intended goal of bringing together theory and practice (Williamson, 2004). There is no doubt that LPs maintain a strong clinical presence whilst providing a formal link between practice and HEIs (Williamson, 2004). However, split loyalties between service and education, unclear career structures, and a heavy workload, limit the effectiveness of the role (Williamson, 2004; Pegram and Robinson, 2002; Salvoni, 2001; Williamson and Webb, 2001).

Despite the use of link tutors, personal supervisors, and lecturer practitioners, there remains a lack of strategic management of the clinical role of nurse lecturers in HEIs (Day et al., 1998). However, the individual desire of nurse lecturers to maintain a clinical role appears strong. Carlisle et al. (1997) found that over 80% of nurse lecturers in a survey group expressed a wish to increase their clinical role. To facilitate this, some lecturers have developed individual strategies for enhancing their presence in practice.

For example, Humphreys et al. (2000) argue that nurse lecturers should assist students in developing learning contracts and then directly observe the student in practice to enable assessment of performance in partnership with the clinical mentor. Murphy (2000) introduced a similar model, in which practitioners and nurse lecturers jointly facilitated weekly tutorials for student nurses in clinical settings. Students, practitioners and lecturers evaluated these sessions very highly, and the model provided a method for nurse lecturers to maintain a strong clinical role without needing to provide physical nursing care (Murphy, 2000). Bentley and Pegram (2003) provide a description of their ability to regularly perform clinical shifts as part of the nurse lecturer role, highlighting the importance of this to their development, and reporting positive feedback from students and practitioners.

The strategies developed and reported by individual lecturers appear popular with staff and students, and useful for maintaining the clinical skills of educators. However, there is little evidence provided of wider benefits for clinical practice or HEIs. Time constraints due to academic commitments also provide a barrier to the widespread implementation of systems involving regular supervision or teaching of students in practice.

The case for a clinical role

The organisational and individual models used to enhance the clinical role of nurse lecturers have
been partly driven by policy. However, there are educational and professional issues cited as reasons to maintain a clinical role.

One of the most common arguments in favour of a strong clinical role is that without regular exposure to practice, lecturers will not maintain their 'clinical credibility'. This rather nebulous expression, often used interchangeably with terms such as clinical competence or clinical currency, is regularly cited in policy documents and opinion pieces surrounding the nurse lecturer role (Fisher, 2005).

Where definitions exist, clinical credibility is usually associated with students' perceptions of the lecturer's ability to apply theory to practice (Fisher, 2005). The importance of maintaining clinical credibility is often linked to research findings suggesting that pre-registration student nurses feel that lecturers are either out of touch or have a very low profile in practice (Henderson, 2002).

To evaluate the significance of clinical credibility, it is necessary to explore two main questions — How can nurse lecturers develop and maintain clinical credibility? Does it enhance the effectiveness of teaching?

The lack of any agreed definition of clinical credibility means that there is no clear framework for maintaining it. Some authors argue that it can only be achieved by actually providing nursing care in the clinical environment (Pegram and Robinson, 2002; Gilmore, 1999), whilst others suggest that activities such as clinically orientated research or involvement in practice development are sufficient (Maslin-Prothero and Owen, 2001; Cahill, 1997).

It is arguable that given the wide teaching remit of the nurse lecturer, particularly in pre-registration nursing, clinical credibility in all areas of teaching is an impossible goal (Maslin-Prothero and Owen, 2001). Within clinical areas, there is no expectation for practising nurses to have knowledge or credibility in all specialities, and it seems unrealistic to expect nurse lecturers to achieve this goal.

In terms of the effectiveness of teaching, authors who advocate a clinical role for nurse lecturers provide a simple argument — to teach effectively, lecturers must update their skills by regularly participating in 'hands on' care (Pegram and Robinson, 2002). Without this activity, students will view nurse lecturers as being disassociated from practice, which will in turn hinder the process of learning (Pegram and Robinson, 2002). In order to critique this argument, it is necessary to clarify the fundamental aims of teaching, and discriminate between the different needs of classroom and practice teaching.

Transfer of knowledge — general concepts taught by the lecturer being applied in specific circumstances by the student — is often seen as the primary goal of classroom educators (Lauder et al., 1999; Marini and Genereux, 1995). There is consensus that nurse lecturers themselves require knowledge of the subject area to enable transferable — and therefore effective — teaching (Lee et al., 2002; Gillespie, 2002).

Benner (1984) discriminates between theoretical knowledge ('knowing that'), and practical knowledge ('know-how'). Whereas theoretical knowledge can be developed and maintained through scholarly activities such as reading journals, writing for publication and carrying out research, practical knowledge requires actual clinical experience (Benner, 1984). Within the classroom, it is theoretical knowledge that will be delivered — broad concepts that can be transferred to specific clinical situations and underpin the development of practical knowledge. To facilitate this, the lecturer need arguably only demonstrate sound theoretical knowledge of the subject area.

Humphreys et al. (2000) dispute this, suggesting that even for classroom teaching, a level of practical knowledge and clinical credibility is required. By being familiar with the realities of clinical nursing practice, the nurse lecturer can enhance theoretical teaching using real-life examples and anecdotes, thereby facilitating transfer (Humphreys et al., 2000). However, little evidence is available to support or refute the importance of clinical credibility as an aid to facilitate transfer of theoretical knowledge to practice (Murphy, 2000).

It may be hypothesised that too much expertise in one area of clinical practice could actually be detrimental to the classroom teaching of transferable knowledge. Specific knowledge and skills, delivered by a nurse lecturer credible in that speciality, are transferable to a limited range of situations (Lauder et al., 1999). Broader knowledge is applicable to a wider range of transfer opportunities (Lauder et al., 1999) and could be taught by lecturers with less specialist knowledge.

It should be recognised that nurse lecturers deliver content to student groups with different abilities and needs, and the skills and attributes required by the lecturer will vary accordingly. Benner (1984) argues that teachers of novice (pre-registration) nurses need not demonstrate a high level of expertise underpinned by practical knowledge. However, those nurses seeking specialist post-registration education will expect their lecturers to display a high level of clinical expertise (Benner, 1984). This argument would suggest that only those lecturers teaching on post-registration specialist courses require clinical credibility.
The actual transfer of knowledge to specific clinical situations occurs in practice. The student within this environment therefore has different learning needs from that required in the classroom, and the teacher must display different attributes. Social Learning Theory has often been cited as an important theory in the context of nurse education (Bahn, 2001). In particular, the concept of students modelling their behaviour on the practice of more experienced staff has great relevance to the way in which student nurses learn in practice. To facilitate effective role modelling, student nurses should be taught in practice by an expert practitioner (Bahn, 2001). This argument is congruent with the findings of a study by Lee et al. (2002) in which student nurses rated 'good role model' as the most important characteristic of clinical educators. Another concept linked to the learning of student nurses in clinical practice is that of 'scaffolding'. In scaffolding learning, an expert practitioner identifies the learning needs of the student and then guides them through any aspects of care that the student is unfamiliar with (Spouse, 2001).

If role modelling and scaffolding are accepted as key learning methods for students in practice, it is clear that these students require regular contact with clinically skilled teachers during placements (Gillespie, 2002; Spouse, 2001). However, it is less clear whether these teachers need to be nurse lecturers, lecturer-practitioners, or members of the clinical team in placement areas.

The teaching of students on clinical placement by nurse lecturers has been the subject of a number of papers, and it is generally accepted that students expect lecturers to visit them in practice (Humphreys et al., 2000). These visits may involve a teaching element, but predominantly focus on providing support and advice. Brown et al. (2005) found in focus group interviews with pre-registration students that visits to clinical practice by lecturers were extremely useful. Visits were given great value not only because they provided students with support, but also because the prospect of a visit motivated students to carry out preparatory work (Brown et al., 2005). Despite these qualitative findings, it should be noted that no empirical research has been completed that addresses for need for nurse lecturers to provide support to students in clinical areas (Lee, 1996).

It has been suggested that lecturers should provide regular teaching to students in practice, as clinical mentors often lack the time or the expertise to integrate theory with practice (Ioannides, 1999). However, this standpoint fails to appreciate the efforts made to develop the role of clinical mentors since the initiation of Project 2000.

Clinical mentors are experienced members of the nursing team in practice areas with responsibility for facilitating learning, supervising, and assessing students (NMC, 2004; Spouse, 2001). Formal mentorship preparation programmes equip nurses with the skills required to facilitate clinical teaching and assessing (ENB and DH, 2001). Given that the educational credentials of clinical mentors have been enhanced significantly, it could be argued that practitioners alone should hold responsibility for clinical teaching and assessment. The extension of that argument is that to provide a purely supportive role for students on placement, lecturers need not maintain the attributes necessary for practice teaching, such as clinical credibility.

Beyond discussion focused purely on the effectiveness of teaching, there lies a more fundamental issue underpinning arguments for a clinical role for lecturers — the theory–practice gap. It has been suggested that nurse lecturers who have lost their clinical credentials will not have a realistic perception of practice and the content that they teach will not resonate with the practice that students observe (Gidman, 2001). Though inextricably linked to the effectiveness of teaching, the theory–practice gap can also have a wider influence on the relationship between education and practice by devaluing clinical skills and alienating academics (Hewison and Wildman, 1996).

Humphreys et al. (2000) suggest that within the classroom, clinically credible nurse lecturers can narrow the theory–practice gap by basing teaching on a more realistic picture of what occurs in practice. This argument is flawed by the simple fact that clinical practice may demonstrate uneven standards of care and a failure to base practice on evidence. Not only would it be impractical to try to base teaching on the realities of the clinical environment, but may also run the risk of perpetuating bad practice.

The discussion can be turned around and the emphasis placed upon the lecturer enhancing the standards of care provided in practice, to bring them into line with the ‘idealism’ taught in the classroom. The lecturer could act as an agent of change, encouraging a culture of evidence-based holistic care in practice areas (Landers, 2000). The difficulty with this argument is that lecturers currently have neither the time nor the mandate to facilitate this degree of change in clinical areas. Ramage (2004) found that attempts to develop and enhance clinical practice by nurse lecturers were often resisted by nursing staff who felt threatened by an ‘outsider’ proposing to change their working practices. Interestingly, some nurse lecturers
reported that to reduce resistance to their presence, they conformed to the norms in practice areas, even if these did not meet their usual standards of care (Ramage, 2004).

**Recommendations**

One of the main arguments against developing the clinical role of nurse lecturers is that the employing HEIs are unlikely to provide additional time for lecturers to practise clinically (Kenny, 2003). To overcome this, a re-evaluation of staffing numbers in HEIs is warranted. In pre-registration nursing, the recommended staff:student ratio is 1:15, compared to 1:10 in midwifery education. The higher staffing ratio in midwifery education is due to an ethos of active clinical support from midwifery lecturers (NMN, 2004). If pre-registration nurse lecturers are to be expected to maintain a similarly ‘hands-on’ role, as alluded to by the NMC and explicitly argued for by a number of authors, then nurse lecturer numbers should be increased to match the equivalent figures in midwifery.

Increased numbers of nurse lecturers could allow the development of a model of nurse education incorporating the North American concept of ‘faculty practice’. Faculty practice involves contractual agreements between educational facilities and clinical areas, through which formal arrangements are made for tutors to work in practice (Saxe et al., 2004). Although a number of different organisational models exist for faculty practice (one of which bears resemblance to the current lecturer practitioner role) the ethos remains the same – nursing tutors must remain clinically active to retain skills and develop knowledge (Gilliss, 2004).

Alternatively, the requirement for a clinical role could be re-evaluated in light of the changing context of nurse education within the UK. Clinical mentors are now given enhanced educational preparation, and health care organisations employ a number of practice educators and nurse consultants. This, along with the ongoing recruitment of lecturer practitioners as joint appointments between practice and education, raises the question of whether full-time lecturers need to have a presence in practice. Given the increasing amount of clinical support provided, nurse lecturers could relinquish their responsibility for clinical teaching, and focus wholeheartedly on their academic role in Higher Education — teaching of theoretical concepts, writing for publication, and completing research (Rolfe, 1996). Calpin-Davies (2001) suggests that education itself should be seen as a speciality of nursing in the same way as (for example) continence care or infection control are seen as distinct career paths for clinical nurses. If this were indeed the case then the perceived importance of providing ‘hands on’ care would give way to a recognition that nurse lecturers contribute widely to nursing practice through teaching and research (Murphy, 2000).

The option of making the nurse lecturer role a purely academic one would help resolve the issues surrounding workload and role clarity. However, the danger is that the perception of nurses in practice will shift further towards one in which academics have little clinical credibility.

Between a formalised system of faculty practice and a total withdrawal of academics from clinical practice, there lies a compromise solution. The answer to the quandary of the nurse lecturer’s clinical role is not a broad-brush approach that standardises arrangements for all lecturers and HEIs. Instead, individual HEIs must employ innovative recruitment strategies to ensure that every department of nurse education contains a mix of lecturers with different specialities, interests and abilities. Much of the literature and policy related to the clinical input of academic staff casts nurse lecturers as a homogenous group of professionals all delivering similar content and performing similar roles. In order to move the debate forward, this misconception should be addressed.

There is little doubt that the expectation of nurse lecturers to carry out four distinct roles to a high standard — teaching, research, clinical, managerial — is unrealistic (Calpin-Davies, 2001). Instead, some lecturers will retain a strong clinical role, and be best suited to teaching in practice or delivery of post-registration specialist nurse programmes. Those lecturers who wish to maintain a clinically active role should be supported by their employing HEI through the faculty practice model of formalised agreements with clinical partners and the allocation of protected time (Rattray, 2004). Some lecturers will become experts in the art of education, therefore making them ideal for the delivery of programmes to prepare mentors and practice educators. Some nurse lecturers may relinquish all of their clinical input, but will become leaders in research and publication — developing new knowledge and raising the profile of nursing.

All lecturers should strive to raise clinical standards in practice. However, this cannot be done purely through a piecemeal approach of trying to implement change in individual link areas. Lecturers’ contributions should be much broader in their impact — for example, producing research that
provides a catalyst for organisational change. Most importantly, lecturers can enhance clinical standards by teaching best practice to the students in front of them.

Conclusion

This article has explored the clinical role of nurse lecturers in terms of four main areas — policy, strategies for enhancing the role, the arguments for and against a clinical role, and recommendations for a way forward.

To implement national policy and facilitate a formal role in practice for nurse lecturers, HEIs have adopted a number of options, such as link tutor roles or the employment of lecturer practitioners. These initiatives have had limited success and it is now time to re-evaluate the need for, and likelihood of, all nurse lecturers maintaining a clinical role.

Within the domain of post-registration specialist education, and in regard to teaching in clinical practice, persuasive arguments exist for ensuring the clinical credibility of lecturers. In these cases, lecturers must feel supported by clinical practice, and by their employing HEI, in the maintenance of a formal clinical role.

For many areas of the pre-registration nursing curriculum, particularly those related to the delivery of theoretical content, clinical credibility is not necessary. Strong knowledge of the subject areas is a prerequisite of effective teaching in all aspects of education, but lecturers maintain this through reading, writing, and research. If members of the nurse lecturer team can feel comfortable in relinquishing their clinical obligations, additional time will allow for increased publication and research output, raising the profile of individual HEIs and nursing in general.

By accepting that a general policy on the clinical role of nurse lecturers is misguided and impractical, HEIs can develop a flexible approach to recruitment and development of staff. By nurturing the mix of skills and knowledge inherent in any team of nurse lecturers, HEIs can strive to meet the needs of staff, students and clinical practice.

References


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