Liberating the potential: The role of non-nurses in adding value to nurse education

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Summary In this paper, I have attempted to explore the role of non-nurse lecturers in adding value to nurse education programmes. In measuring 'added-value' in higher education, I have embraced a more comprehensive approach including investigating the views of 'Experts': including the nurse and non-nurse lecturers themselves, and various United Kingdom stakeholders such as the Government, the Nursing and Midwifery Council and the Quality Assurance Agency. The students' views are also taken into account, when considering both the content of the programmes and how they are delivered. The complexity of 'objective measurement' is considered, and the requirements of a 'good' teaching experience.

The potential areas for adding value include: health and social care policy priorities which encourage partnership working, the blurring of professional boundaries, and inter-professional working. Professional-specific changes embracing extended and enhanced roles and the concepts of specialist and assistant practitioners. Other areas include the Higher Education agendas including transferable skills and adult and student-centred learning. I conclude by discussing the latest policy changes and suggest that the role of the non-nurse lecturer needs more exploration to provide the best value for all.

KEYWORDS Added-value; Nurse education; Lecturers

Introduction

Nurse education is constantly evolving as nursing develops as a profession alongside the proliferation of health policies determined to resolve the ongoing problems of the British Health and Social Care System.

One major area of change has been the movement of nurse education from Schools of Nursing into higher education establishments. An outcome of this move is the potential for more of the curriculum to be managed, taught and supervised by lecturers without nursing qualifications...
but whose disciplines or professional backgrounds have the potential to provide added value to the experience of nursing students and subsequently to nursing practice. This paper attempts to explore the potential of non-nurse lecturers within a policy, practice and theoretical framework. Although largely informed by English policy and practice, I have included research from other countries as some issues are universal in nature.

Very little has been written about the role of the non-nurse in nurse education, and what has been published tends to use a deficit model, i.e. an ideological view that not having a nursing qualification is seen as a problem especially in relation to the gap between theory and practice (Hughes, 1991). No substantial work has taken place to explore the potential of these lecturers in adding value to the theory and practice of nursing.

I have used Woodward's (1993) four approaches to measuring 'value-added': expert systems, students’ views, objective measurements, and systematic and critical appraisal in order to provide a framework for discussion.

**Expert systems: the lecturers**

The first approach to consider, and possibly the easiest to obtain evidence from, is the use of 'Experts'. How you define these are not without its problems but for the benefit of this discussion it includes key stakeholders, writers and of course the lecturers in nurse education. Most writing on the lecturer's role in nurse education is written by nurses about nurse lecturers. This is not surprising as, taking my faculty’s staff profile as an example; more than 90% of the lecturers will be nurses. The role of the non-nurse is not directly represented in many articles or books; however, as with the policies, some general themes can be extracted to support the discussion.

Non-nurse lecturers have written extensively about all manner of subjects but very little (as stated above) in relation to their role in teaching nurses. An exception to this was Sheila Stark then at the Institute of Health Studies, Colchester (Braithwaite and Stark, 1992), who wrote with a nurse colleague in response to an article by Pat Hughes (Hughes, 1991) on 'Who should teach nurses'. Nurse education was getting more established in higher education and Hughes (1991, 1992) suggested that it was time to explore these issues. Hughes' views were largely negative and again mirrored the deficit model with concerns over applying theory to practice, but seemed more concerned with the 'status’ of nurses, including the low status of applied knowledge and the threat to jobs for nurses. Her main thread seemed to be about concerns for the profession rather than the students’ experience. This concern is supported by Owen (1988) in that one of the visible outcomes of nurse education moving into HE, that of sharing skills, could result in other disciplines taking over. This 'tribalistic' behaviour can be seen as common within professions (Basford, 1999). Stark and Braithwaite disputed this by saying that the practice of according lower status to nurses had not arisen in their institute, and that nurses and non nurses working together 'can be mutually beneficial rather than mutually exclusive (Braithwaite and Stark, 1992, p. 26). This beneficial outcome for nurse and non-nurse lecturers was one of the reasons why nurse education moved into HE, it was felt that it would help to establish nursing alongside other professions and disciplines (Deans et al., 2003).

In considering the possible added value of non-nurses, Stark and Braithwaite argue that non-nurses could help to provide a holistic education for nurses: a total experience rather than narrow or compartmentalised, therefore more reflective of real life. They go on to suggest that the power of the existing culture in which nurses’ work feeds back into education, preventing the changes needed in the culture and practice of nursing required for present and future healthcare delivery. Non-nurses should be encouraged to contribute to the culture and, therefore, be part of the day to day business of nurse education. "... if nurses feel threatened by their exclusive territory are they not hindering the practice of education which offers possibilities of liberating the profession from out-moded relations and structures?" (Braithwaite and Stark, 1992, p. 27).

Hughes (1991, 1992) thoughts on adding value were about non-nurses being subject specialists and allowing nurse tutors to develop their clinical role, thus raising two interesting points for the role of nurses as lecturers in Higher Education. First, what about the development of them through scholarship and research, essential for moving the profession forwards? And second, it could be argued that their practice is surely that of educator and the clinical role is best left in practice or with the new role of lecturer practitioners (Gallagher, 2004).

**Expert systems: the stakeholders**

The stakeholder views tend to be relayed via policy statements and strategies, with the only direct mention of non-nurse lecturers coming from an
Students' views

Exploring student’s views should be the first consideration when assessing the value of lecturers: However, in relation to nursing it could be argued that the patient, the ultimate receiver of ‘practice,’ is the most important judge. This section is concerned with the content: what the students want or need to know, ‘wants’ being very much the students’ perspective, and ‘needs’ dictated by the many stakeholders involved in nurse education.

The obvious place to start when considering how non-nurses can contribute to the content of nurse education is with a definition of nursing. The Quality Assurance Agency (QAA), when devising the nursing benchmarks, defined it as an academic and applied profession (QAA, 2001) and, rather than attempt to discuss the many definitions, described it through the branch specialisms of adult, children’s, mental health and learning disability nursing. This method is shared by the National Health Service (NHS) careers service, which also adds midwifery and health visiting within the ‘family’ of nursing (NHS, 2004).

The content in pre-registration education is defined by what is needed to register with the professional body, the NMC, who also approve the programmes of study. For post-registration training, the NMC decided not to be directly part of the approval process as the ENB had been earlier, unless the qualification is ‘recordable’, as with nurse lecturers, health visitors, etc. Therefore, the content requirements are dictated by the many health care policies and guidance discussed earlier.

The ‘academic’ nature of nursing content could be defined by subjects such as anatomy, physiology, sociology, etc., and of course by nursing theory itself. Whether non-nurses can provide added value in this area is debatable. Braithwaite and Stark (1992) state that subject experts can provide a wider depth of knowledge and can team teach for the applied nature. This is supported by the ENB (1987) but only if nurses themselves were unable. This could be deemed to under-value the importance of many disciplines in HE. In considering what the students ‘want’, they seem to prefer anatomy and physiology in the curriculum rather than some of the social sciences (Clarke, 2004); however, both could be taught by non-nurses.

The ‘applied’ nature of nursing content could be seen as nursing practice and therefore more concerned with clinical skills, which seem to be more likely to be successfully taught in practice, as demonstrated by evaluations of the project 2000 pre-registration programme (Ramritu and Barnard, 2001). However, the applied skills more associated with current policy include partnership working, evidence and enquiry-based practice, and transferability of roles (QAA, 2001; DOH, 2002; UKCC, 1999). These are all areas where it could be argued that they could be delivered by all educators whatever their background.

Looking wider at students’ needs brings us to the importance of the students understanding the
nurses’ position within a social, political and economic context (QAA, 2001). This is supported by an Australian study into what nurses in practice felt student nurses needed. It showed that more general skills development was required including critical thinking and the skills for life long learning, to equip the profession for growth and change in the future (Cheek and Jones, 2003). These skills may also help to address another student ‘want’, where students deduce what works and what is irrelevant in the classroom based on existing practice (Clarke, 2004), this questioning of practice is essential to equip the student to be ‘evidence-based’, and an ideal role for the non-nurse (Brathwaite and Stark, 1992).

**Objective measurement**

This approach is used most frequently in measuring value-added in Higher Education (HE) (Storey, 1993).

’A measure of student achievement, as indicated by exit qualifications, which takes into account differential inputs, as indicated by entry qualifications’ (PCFC/CNAA, 1990, p. Summary).

Although seemingly straightforward in comparing inputs with outcomes to measure the value-added and having that so called ‘gold standard’ for objectivity, by its very nature it fails to consider the many factors impacting on the student experience (Gibson, 1993), and that of course includes the role of the lecturer. For comparison purposes, it is limited as it is not universally used throughout HE (Lund and Jackson, 2000).

Although the criticisms of this approach are valid and it could be debated whether we can ever be truly objective, huge ‘leaps of faith’ are made in relation to the assessment of value in nurse education with no or little attempt at analysis. The main area where this seems to arise is the concern over the degree to which objective assessment of both the academic and clinical elements of nursing is possible; once again the theory and practice gap!

Before considering the role of the non-nurse lecturer as one of the many factors impacting on the student experience, it is useful to explore the ‘Inputs’ and ‘Outcomes’ in relation to nurse education.

‘Inputs’ (i.e. what the students initially bring to the education experience) in nurse education are largely measured by qualifications. But with the widening of the entry gates including cadet schemes, access and part time routes, specific educational requirements are being eliminated (Kenny, 2004).

All nurse education programmes, whether pre or post-registration, assume that what the student brings with them (i.e. ‘Input’) provides the basic ability to commence their study. This baseline measure needs to be consistent within and across institutions in order to measure added-value objectively. It is, therefore, dependant on clear guidelines of what is needed to access nurse education. The big question here, as in all educational programmes, is to consider what can be learnt within the scope of the programme and hence decide what the students need to bring with them. One of the latest changes came from the Nursing and Midwifery Council (NMC, 2004a) concerning new literacy and numeracy requirements. Although seeming to provide clarity, they suggest that higher education institutions work with local service providers to set their own criteria for entry in order to fulfill these requirements, which will surely lead to more differences between institutions. Interestingly the same circular relates to another ‘Input’ in accessing nurse education: that of personal attributes, with the importance of measuring good health and character in relation to working to the code of conduct (NMC, 2002b), resulting in formal guidance (NMC, 2004b), an example of inputs based both on academic requirements and personal attributes! This in itself can hardly be objective as lecturers interview and select potential students, and their understanding of what a ‘good’ nurse should be will depend on many factors, including when they trained and their view of nursing (Holloway and Penson, 1987).

Assuming a solid input base is obtained of measurable ability, the next area to consider is the ‘Output’. In nursing, especially pre-registration, this may seem simple: i.e. Fitness to Practice.

The Nursing and Midwifery Council (NMC), through their Quality Assurance arm, validate pre-registration programmes (UKCC 2001/NMC 2002), thus deciding on the ‘Outputs’ needed to be competent to practice as a nurse. They also validate post-registration programmes that lead to a recordable qualification such as Health Visiting. It is up to the ‘education provider to assess academic and practice competence within these guidelines. Alongside the NMC guidelines sit the Quality Assurance Agency (QAA) Subject Benchmarks (QAA, 2001), which exist in order to describe the nature and characteristics of programmes of study. Split into shared statements and profession specific, they need to be considered alongside nursing

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1 I do not think that the NMC validates PGCEs any more, even if it could. Lecturers do not now need to ‘record’ a teaching qualification with the NMC to work in a University department.
competences for registration with a statutory body (QAA, 2001, 2004). The QAA suggest that the Benchmarks provide support to internal quality assurance, and also of course for overall quality review purposes.

Just as it might seem that the ‘Outputs’ cannot get more complicated the National Health Service (NHS) adds a new dimension with the ‘Core Dimensions and Specific Dimensions’ of the NHS Knowledge and Skills Framework (DOH, 2003a). This is linked to pay analysis and pay progression for all NHS staff. The dimensions have levels depending on knowledge and skills and are linked to current NHS policies.

Acknowledgement of the current complexities of quality assurance is made by Department of Health in its 'Streamlining Quality Assurance in Health Care Education' paper (DOH, 2003b), (which through partnership) it states is attempting to integrate the processes and outcomes based on the delivery of ‘patient-focused learning’.

As stated earlier, in nurse education the outcome of the students’ educational experience could be measured by the effect on the nursing practice on the patient. This measurement adds another set of variables. In relation to the attainment of the key skills needed to practice as a nurse such as critical thinking, reflective practice and working in teams, Swindells and Willmott (2003) suggest that graduates perform better than diplomates.

Looking at other 'Outputs' concerning clinical skills, a study in Pennsylvania attempted to explore whether the educational level of nurses (i.e. Diploma or Degree) impacted on surgical patients’ mortality (Aiken et al., 2003), and went on to suggest that the conventional wisdom that experience is more important than education may be incorrect. The results showed that a 10% increase in the proportion of nurses holding a four year degree was associated with a 5% decrease in patients’ deaths. In a discussion on the implications of the research (Long et al., 2004), Long questions why the nursing profession find the idea of education being important to nursing practice controversial. Although a long way down the road from the impact of a non-nurse lecturer to the practice of a surgical nurse, it shows not only the potential and complexities of objective measurement but also the underlying value bases still informing nurse education.

Returning to the main theme of this paper, the contribution of lecturers (never mind the non-nurse lecturer) is one of the many factors that impact on the student experience (Gibson, 1993), and therefore complicates the ‘Input’ and ‘Output’ measurement. Although the research of Swindells and Willmott (2003) and Aiken et al. (2003) suggests the importance of higher educational attainment for nurses, the authors do not mention factors which may contribute to this attainment.

The main opportunities for measuring the impact of English non-nurse lecturers are the reviewers as part of the Major Review of Health Care Programmes (QAA, 2003), who work in conjunction with the nursing profession through many guidance documents, including for example, the Requirements for Pre-Registration Nursing Programmes (UKCC 2001/NMC 2002). Although the reviewers do not attempt to measure the added value of any variable on the educational experience of the student, they do make quality judgments on what is considered best practice. Aspects related to lecturers include the importance of the learning opportunities reflecting profession-specific competences and outcomes, patient-centred practice and professional code of conduct requirements, alongside evidence based learning, holistic care, partnership and inter-professional learning (UKCC 2001/NMC 2002), a challenging set of ingredients for any lecturer to consider. The QAA (2003) adds to the recipe emphasising the importance of the teaching process, valuing 'breadth, depth, and pace', and the challenge for the teacher in using a variety of teaching methods. They also expect effective subject and inter-professional knowledge, which is transferable, and supports practical and professional skills (QAA, 2003). The scope for any lecturer to provide added-value to this menu is both considerable and challenging, and whether lecturers need particular characteristics is as yet not discovered.

Systematic and critical appraisal

This is the final area to consider in Woodward’s (1993) framework. It clearly overlaps with the other three approaches and is fundamentally about measuring what makes a good teaching experience, and in relation to the theme of this paper, if non-nurse lecturers are able to deliver these requirements.

The first issue to consider is that of professional education and whether the teaching requirements differ in HE to less applied and controlled disciplines. Policies and guidance discussed earlier all state some differences to do with the applied nature of professions such as nursing, but also stress the importance of transferable and evidence-based skills common to all disciplines in HE.

The culture of the nursing profession will also have a huge influence on how things are taught. This, alongside the move into HE with its different value systems based on freedom of expression, can
be in conflict with nursing especially in practice (Castledine, 2003). The move also encouraged a change in educational styles towards practices based on adult learning philosophies and the use of life experiences (Kenny, 2004). The hidden curriculum in nursing is also very powerful. Holloway and Penson (1987) discuss the differences that students experience alongside their peers in HE such as less freedom of choice of what to study, clinical placements, and a culture of ‘busy-ness’. The code of conduct requiring ethical behaviour and the hierarchical nature of the profession all still exist at some level in nurse education. Basford (1999) also discusses the tribalistic behaviour of professions and the need to ensure that teachers are adequately prepared to take on the role of teaching across disciplines, not only with an educational dictate, but also across socio-cultural, psychological and affective domains.

“‘We must accept that teaching is a political activity, and be aware that everything we teach is value-laden and that neutrality is a myth’ (Harden, 1996, p. 35).

Non-nurses can enrich this culture and help to challenge unhelpful aspects of professionalisation (ENB, 1987; Braithwaite and Stark, 1992).

Academic and transferable skills, including critical thinking and life-long study skills, seem to be the main area requested by past and current students (Cheek and Jones, 2003; Raaheim et al., 1991) This need to prepare nurses to be enquiring and reflective should also encourage the challenging of existing norms (Taylor, 1993), essential for a profession that seems largely apolitical in nature but politically controlled. The opportunities for non-nurse lecturers could be invaluable here in encouraging the development of skills free from the confines of belonging to the profession. This can also relate to the area of professional ethics.

The role of the non-nurse becomes less clear when exploring clinical outcomes and competencies. However, the UKCC (2001)/NMC (2002) and QAA (2003) guidance all cite the importance of inter-professional and team working; ideal areas for the non-nurse.

Future considerations

At the time of writing, there are significant changes taking place to research and define quality in terms of lecturing in higher education in England. The NMC (2004c) are consulting on ‘Standards to support learning and assessing in practice’. In respect of the non-nurse lecturer the title of the document would suggest that it has little relevance to considering the value of the role. However, it does acknowledge, the importance of reflecting the inter-professional agenda and the changing context in Health and Social Care.

All lecturing in HE is being considered by the Universities UK/SCOP/HEFTC, Higher Education Academy (2004) consultation paper on establishing a ‘Framework of Professional Teaching Standards’. It cites the importance of exploring all factors involved in the quality of higher education teaching as recommended by the Dearing Report (NCIHE, 1997) with the need to commission research into teaching and learning practices in HE. The paper acknowledges the importance of the role of the professional organisations in the development of their own standards, but feels these standards for all teachers in HE would help with the connection between HE and professional and subject specialist organisations.

In conclusion, my perspective and, therefore, obvious bias comes from being a non-nurse lecturer in nurse education. As practice catches up with policy and patients’ needs, let us hope that the education of nurses mirrors this change with more Schools of Nursing becoming Faculties of Health and Social Care, and inter-professional learning and practice becoming more of a reality. This article fully supports the role of nurses in leading nurse education, but suggests that a useful resource outside the profession is been underused. We need to ‘liberate the potential’ of all stakeholders in nurse education to provide the nurses we need for the future.

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