The nurse lecturer role in clinical practice conceptualized: helping clinical teachers provide optimal student learning

Kathryn J. Ahern

Despite the fairly wide reporting in the literature of the many roles of clinical supervision by the nursing teacher, little attention has been given to conceptualizing the relative priorities these roles take during the process of supervising nursing students in clinical practice. The purpose of this paper is to consider the manifestations and implications of conflicting roles when nurse lecturers undertake clinical supervision. Previously published research will provide working examples of issues in a conceptual framework for clinical teaching.

Introduction

This paper describes a conceptual framework that explores the attributes of optimal teaching roles of nurse teachers/lecturers in clinical settings. The purpose of this paper is not to go over old ground, but to re-conceptualize the issues to provide a cohesive framework for future research and practice.

In order for nurse teachers to function effectively in the clinical area, there is a need for role clarity and mechanisms to avoid role conflict (Clifford 1996). However, it is generally acknowledged that there is a lack of role clarity for nurse teachers in the clinical supervision of students (Paterson & Groening 1996, Van Ort & Putt 1985, Weinholdz & Ostmoe 1987). This is the result of nurse teachers experiencing time constraints, needing to do things other than teaching itself (Harri 1996), not feeling part of the ward team, having limited influence and experiencing a lack of trust and mutual respect between themselves and practitioners (Davies et al. 1996). In addition, the teaching role on its own is difficult to implement because clinical observation and evaluation are often conducted in settings with clients present (Ferguson & Calder 1993). Issues of the lack of role clarity of university-employed clinical teachers continue to be of ongoing concern worldwide (Clifford 1996, Crotty 1993, Harri 1996).

A wide range of nurse-teacher clinical supervision roles has been identified in the literature. These include: liaison between college and practice area, supporting and monitoring student progress, negotiating placement allocation, helping students to achieve objectives, challenging students' old habits, teaching them to become more self-reliant, recognizing signs of client distress, maintaining client safety and reporting pertinent information to the relevant ward staff (Crotty 1993, Davies et al. 1996, Ferguson & Calder 1993, McAllister & McLaughlin 1996). These diverse functions can be grouped into three main role categories: that of (1) nurse teacher, (2) colleague and (3) carer.

Positive practice learning environments are those where there are clear boundaries for each of these role categories and where the interactions of one role category take conscious precedence over the interactions of the other two categories. In such an environment, teaching is both client-centred and student-centred (Davies et al. 1996). The conceptualization of clear role boundaries is achieved by the prioritization of the role categories so that optimal clinical teaching leads...
to optimal student learning and, ultimately, optimal client care by the student. In this way the nurse teacher can meet many of the conflicting situational demands because he or she is fostering an environment in which the student develops the capacity to take on more than just the role of supervised care-giver.

**Conceptualizing what clinical teachers do**

Nursing students develop their professional value system through their interactions and associations with other nurses, health professionals and clients (Ferguson & Calder 1993). This includes observing the interaction between the clinical teacher and other people in the clinical setting.

**Optimal balance: teacher facilitating student functioning**

The interactions between the clinical teacher, colleagues and students contribute to the development of the students’ professional value systems. Thus, a nurse teacher who is committed to optimizing students’ clinical experience provides a basis for the development of positive professional values.

The balance of role categories is a dynamic process and is primarily achieved through the reflexivity of the nurse teacher. Myerhoff and Ruby (1992: 307) defined reflexivity as ‘the capacity of any system...to turn back upon itself, to make itself its own object by referring to itself’. For the nurse teacher, this entails the honest examination of the values and interests that may impinge upon his or her work (Porter 1993). Nurse teacher reflexivity includes being self-aware enough to treat students as individual people rather than as subjects of the teaching process (Brown 1993), and being open, honest and natural with the students and encouraging them to reciprocate (McAllister & McLaughlin 1996). It also includes the willingness on the part of the clinical teacher to share power (Brown 1993). Nurse teachers who are willing to abandon the authoritarian, controlling practices that generate student dependency must make a shift from evaluator to facilitator of learning. Such a teacher must be willing to be less of an advice-giver and rescuer than one who facilitates the student’s exploration of nursing practice (Paterson & Groening 1996).

![Fig. 1 Model of ideal clinical teaching relationships.](image)

The major roles and role interactions of the clinical teacher are conceptualized in Figure 1. The interactions have been classed as either primary or secondary interactions.

The solid line represents primary interactions, which are the interactions that take place in the working life of a nurse and which to a large extent, cannot be learned in the classroom or laboratory setting. The opportunity to experience primary interactions is a major purpose of clinical practice. Primary interactions are those that occur between the student and the client, client’s family and others such as health professionals and support staff. As can be seen in Figure 1, the focus is on optimizing the student’s nursing relationships with the client.

Secondary interactions are those that are supportive of the student and client and are necessary to facilitate learning in the clinical setting. These include (1) interactions from student to teacher such as demonstration of performance, questioning and responding to questions; and (2) interactions from teacher to student such as questioning, explaining and giving feedback. In the clinical setting, these interactions can be considered secondary because they normally do not directly influence the development of the primary student–client relationship.

In this model, the student–client–other relationships are the predominant ones, and the teaching interactions should provide the necessary learning experiences and support without subsuming the student’s role of caregiver and member of a profession. The challenge to the nurse teacher in clinical practice is to teach the student and to supervise care of the client without diminishing the student–client, student–other rapport.
When things go wrong

Erosion of these primary interactions might occur as the result of the teacher providing instruction and/or feedback inappropriately in front of the client or others. Figure 2 provides a conceptualization of this situation.

This figure conceptualizes a situation where the teacher–student interaction is the predominant one. This situation can occur in one of two ways. The first is when the teacher does not keep a professional distance and a friendship predominates to the extent that the teaching/learning process suffers. While the development of a personal friendship with a student is not a problem in itself, a potential difficulty arises in the teacher’s ability to move between the professional and friendship roles. Where adequate separation of roles does not occur, the development of an inappropriately balanced relationship can manifest as a tendency of the teacher to foster students’ dependence (Marshall & Marshall 1988, Paterson & Groening 1996).

Therefore, it is the teacher’s responsibility to establish the ground rules of the relationship, monitor student performance and carry out disciplinary action if necessary (Brown 1993). If the teacher cannot maintain the balance between the professional and personal relationship, student learning and client care will probably ultimately suffer (McAllister & McLaughlin 1996). This, in turn, will create stress for both the student and the clinical teacher.

The second way in which the teacher–student interaction can undermine the student–client relationship is when a teacher retains full and inappropriate power over the student. This can lead to an excessive distancing between student and teacher. Nurse teachers who have a need to feel that they are more knowledgeable and expert than students, may be envious of students who excel in certain aspects of their clinical performance. Paterson and Groening (1996) report that nurse teachers experiencing envy of students may attempt to dispel the student’s success by becoming overly critical of the student.

Hanson and Smith (1996) describe this as a not-so-caring teacher–student interaction. It usually involves a teacher who conveys the message that he or she has no time, is unavailable, hurried, insensitive, condescending and not interested in whether or not a student learns. As a result, the student may feel scared, discouraged and powerless (Hanson & Smith 1996). It is unlikely that a student who feels scared and powerless could provide optimal client care or interact confidently with other professionals. Again, the failure of the student to develop professional autonomy will provide an additional strain for the teacher in the clinical setting.

Another way in which the roles can become unbalanced is where the nurse teacher is unclear about the boundaries of client care responsibilities. This is conceptualized in Figure 3.

In this model, the teacher inappropriately takes over responsibility for client care and in so doing takes nursing skills practice and clinical decision-making opportunities away from the student. Furthermore, if a nurse teacher takes over direct client care, both the client and the student might get the message that the teacher does not trust the ability of the student. If this happens, it is likely that the client’s trust in the student will be diminished and the teacher might find himself or herself carrying out both direct client care and nurse teaching. Ultimately this creates more work for the teacher, and undermines the professional image of nursing students in the eyes of the clients.

Of course, there are occasions when it is appropriate for the nurse teacher to take over specific aspects of care, such as when a student is unfamiliar with a procedure or when client safety is at stake. The main point of Figure 3 is that the nurse teacher’s unwarranted intervention in the student’s care of the client will undermine the student’s clinical practice experience.

Role confusion in the opposite direction can also occur where the nurse teacher does not demonstrate concern for the client as would normally be expected. In some cases, it is undesirable for the teacher to engage in direct

---

**Fig. 2** Erosion of primary relationships by the dominance of the teacher/student.
Primary interactions ——— Secondary interactions ————

© 1999 Harcourt Brace & Co. Ltd

The nurse lecturer role in clinical practice conceptualized

Fig. 3 Erosion of primary relationships by the dominance of the teacher/client/other relationships.

Primary interactions ——— Secondary interactions ———

client care with students. This was found to be the case in mental health and intellectual disability areas where the interpersonal skills of the student are the main focus of nursing intervention (Forrest et al. 1996). However, it is not good clinical teaching to provide a role model who is disinterested in optimizing client care. Forrest et al. (1996) reported that student nurses considered that some nurse teachers failed to act on students’ concerns about issues such as quality of care. These teachers were perceived by students as serving to maintain the status quo in the clinical areas through their inaction.

Conclusion

The nurse teacher/lecturer role in clinical practice should be diverse and flexible as there is no ‘right’ or ‘wrong’ way to teach (Forrest et al. 1996). However, by being reflexive and by conceptualizing the interactions and roles according to long term priorities, the nurse teacher is able to meet many demands simultaneously. By providing nursing students with the environment to experience all aspects of the nursing role, the student gains confidence, and professional and clinical skills.

It is important that consideration takes place with regard to the conceptualization of the nurse teacher roles in clinical education, as it is unrealistic to expect the nurse teacher to be all things simultaneously to all people (Carlisle et al. 1996). Appropriate re-prioritization of the major role categories will allow the teacher to conceptualize the long-term as well as the short-term goals of teaching in the clinical area and to become more effective with less effort.

As well as providing a framework for research, the conceptual model provides the nurse teacher with a tool that will ensure the clinical learning experience offers the best possible learning outcomes. It must be noted, however, that reflexivity and flexibility in a clinical teacher can only flourish in an environment of genuine support by the employing agency and nursing colleagues.

References


Hanson L, Smith M 1996 Nursing students’ perspectives: experiences of caring and not-so-caring interactions with faculty. Journal of Nursing Education 35 (3): 105–112


Van Ort S, Putt Q 1985 Teaching in Collegiate Schools of Nursing. Little, Brown & Co, Toronto