Mistaken, misshapen and mythical images of nurse education: Creating a shared identity for clinical nurse educator practice

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**Summary** The hospital-based clinical nurse educator is pivotal to the integration of formal learning and clinical practice. Clinical nurse educators are generally considered to be expert nurses within a particular clinical environment; however, many of those who are expert clinicians suffer some loss of identity when assuming clinical teaching roles. It is necessary to facilitate the expression of identity in order to foster collective agency and to empower individuals and groups. In a healthcare system that is awash with change, the importance of this may often be overlooked.

This paper reports on the process and outcomes of a series of workshops with clinical nurse educators in a New South Wales area health service that sought to create a shared identity and role for clinical nurse educators within the health service. Challenges in role demarcation and delineation of the roles and functions of clinical nurse educators, clinical nurse specialists, clinical nurse consultants, practice development facilitators and nurse educators have been reported. Each of these has overlapping and complementary roles to support learning, however, the primary focus and area of responsibility varies among each of these groups.

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**Introduction**

The role of the hospital-based clinical nurse educator is a pivotal factor in supporting both experienced and inexperienced nurses to apply formal learning to clinical practice. While recognition of the role’s status and value is generally undisputed,
role descriptions and boundaries vary between employing institutions and indeed between wards and units within the same institution. There is also blurring of role boundaries and responsibilities across different categories of nurses who contribute to continuing professional development of nursing staff. Further inconsistencies occur with nomenclature across Australian states and between countries, all of which contribute to a certain lack of clarity in the role’s description and enactment.

Educational preparation for practice professions such as nursing have long recognised that the clinical area is an important, if not the most important, area for student learning (Melia, 1987; Bartle, 2000; Campbell, 2003) as well as for ongoing professional development of nursing staff. It is therefore in the clinical setting that nurses continue to develop their professional identities which are inextricably linked to and modified by, their professional role and responsibilities. The clinical nurse educator’s role is complex and includes the facilitation of an optimum learning environment to facilitate both the development of nurses’ clinical practice (Ferguson, 1996; Scanlan, 2001), as well as the clinical and professional development of core staff members (Mateo and Fahje, 1998). This includes assessment of learners’ practice as well as evaluation of their own teaching role in relation to influencing patient care outcomes (Nicolette and Ulmer, 1995).

Definitions of clinical teaching and learning invariably include some notion that clinical patient care areas provide learners with a context for theory application in preparation for contemporary practice. Teaching and learning episodes may also raise learners’ awareness of the contradictions between theory and practice, or between nursing and educational values (Bartle, 2000; Campbell, 2003; Conway and McMillan, 2000). Implicit in these definitions is the understanding that the effectiveness of the learning is dependent on the quality of the teaching and clinical educators who facilitate activities that support reflection in and on practice assist learners to make sense of their learning.

The attributes of successful clinical nurse educators include critical and reflective thinking, effective leadership and communication skills and possibly most importantly, a commitment to learners and the learning process (Mateo and Fahje, 1998; Ramage, 2004). These findings have mainly emerged from studies into students’ perceptions of effective teaching behaviours (Lee et al., 2002) as well as examinations of clinical nurse educators’ roles and functions. Koh (2002) examines the nurse teacher’s role in the UK, and acknowledges that their workloads and functions have changed significantly over the last decade with an apparent tension between academic teaching and learning in and through clinical practice. In 1996, when writing of the Australian context, Lee noted that similar changes occurred in Australia between the 1980s and 1990s and argued that the 1980s role of clinical teacher with hands on involvement in clinical practice has been superseded by the 1990s role of liaison.

Although the hospital-based clinical nurse educator’s role is recognised as distinct from that of a clinician, it may be argued that clinical teaching is part of every nurse’s role and that the development of clinical teaching practices is part of a the registered nurses’ role development. This begs the question: Must a clinical educator possess expertise in a clinical specialty or should their credibility be developed through their ability to educate effectively? Arguments that support both these opposing standpoints are presented in the literature (Ramage, 2004; Cole et al., 2004; Clark et al., 2004; Calpin-Davies, 2001; Mateo and Fahje, 1998). It is widely believed that the success of clinical education lies in creating and managing context-appropriate learning opportunities within an educational framework and that this necessitates a time commitment than many clinical nurses would be unable to provide given their patient load. The hospital-based clinical nurse educator is a position dedicated solely to the purpose of the continuing clinical education of nursing staff. It does not have a patient load associated with it. There has been considerable questioning of the extent to which positions that are not responsible for the direct provision of patient care are sustainable given the current financial pressures on the Australian health system. Therefore, it is timely to attempt to clarify the role and contribution of clinical nurse educators to the nursing workforce.

It has been suggested that in Australia, major structural changes in the organisation of nursing work have provided a context in which nurses have increased opportunity to influence and lead change (National Review of Nursing Education, 2002). Despite this, the majority of published literature related to the clinical nurse educators’ role focuses on support of undergraduate student nurses in the clinical setting with limited exploration of the role in clinical nurse educators in supporting the continuing professional development of nursing workforce post-registration. In New South Wales, a number of categories of nurse contribute to continuing professional development of nursing staff. The clinical nurse educator role is the most long standing of these and has historically been associated with a training model of nurse education. The introduction of other categories of nurses who con-
tribute to continuing education, coupled with an increased emphasis on constructivist learning approaches necessitates a reconsideration of the clinical educator role in contemporary nursing practice. This paper reports on the process and outcomes of a series of professional development workshops with clinical nurse educators in an Area Health Service in New South Wales, Australia.

Description of the workshops

All clinical nurse educators in the Area Health Service \( n = 27 \) were invited to participate in professional development activity to explore their role. Of these, 18 participated in the two, full day structured workshop activity aimed at facilitating identification of their roles and responsibilities and their related professional development needs.

The use of structured workshops to explore issues in nursing education is entirely consistent with the critical social pedagogy which underpins praxis. Through the use of a structured approach to workshops, we sought to model educative — facilitative education techniques consistent with the principles of practice development, active learning and reflective practice. Structured workshop interaction provides an opportunity to collect data about practice issues consistent with an action research approach and provides opportunity to engage in participative and cooperative enquiry (Conway and Little, 2000). Action research, like context-based education, "\( \text{"takes its cues — its questions, puzzles and problems — from the perceptions of practitioners within particular, local practice contexts"} \) (Argyris and Schön, 1991, p. 86).

All participants acknowledged the importance of a clearly articulated and shared understanding of their roles and functions and the interrelationships among their role and that of others who have educational roles in nursing. All participants in the workshop were made aware of the authors' intention to disseminate the outcomes of the workshops through conference presentation and publication and were invited to indicate if they had concerns re this or would like to coauthor work. There were no objections to further dissemination of the workshop outcomes. In presenting the issues that emerged from these workshops, we wish to acknowledge the contribution made by the participants in consenting to share their experiences and work though publication. We have validated our perceptions of their experience as accurate and representative through distributing an overview of the issues raised in the workshop for comment and endorsement by those who participated.

Recurring issues raised in the workshops suggests that clinical nurse educators confront mistaken, misshapen and mythical expectations of their role, their experiences in the clinical setting reinforcing the dissonance between the rhetoric and the reality of education in clinical practice. There is a plethora of documentation within and external to, the area health service that presents a mythology of clinical education as framed by professional practice standards. Such documentation suggests that clinical education is critical, facilitative, modelled, structured and supported in the clinical setting. However, the clinical nurse educators reported that this ideal is frequently misshapen to become directive; aimed at developing functional rather than professional competence and maintaining, rather than critiquing, the status quo in practice.

For these clinical educators, the ongoing challenge was ensuring that other staff did not have mistaken expectations of their role and associated responsibilities. During the workshops, they expressed concern that there was little to guide their practice and in many cases, available role models did little to facilitate realistic perceptions of the contemporary clinical nurse educator role. The authors suggest this is because those role models are themselves entrenched in traditions of nursing practice and outmoded models of education. Of particular concern was that a significant number of clinical nurse educators who participated in the workshops expressed the view that many nursing unit managers appeared to place emphasis on clinical expertise and skill development at the expense of developing critical inquiry and that this was a major factor in creating role tensions for them as clinical educators.

Professional education as intraprofessional partnership

Nursing education is no longer limited to those who have education in their position title and there is evidence of role blurring and confusion among a number of classifications of nursing staff. Implicit in the roles of clinical nurse specialist, clinical nurse educators, nurse educators and clinical nurse consultants is educational support for learners. The lack of explicit role demarcation among these professional groupings in nursing contributes to limited role identity for clinical nurse educators in particular. This has potential to result in oppressed group behaviour manifested by intraprofessional turf wars, gate keeping, and one-upmanship.

In times of significant change there is heightened potential for the identity of specific groups
to become lost. While individual members of the group may be well aware of the threat to their individual and collective identity, they frequently fail to invest in articulation of their practice and their contribution to the organisation. As is the case with many members of the organisation, clinical nurse educators may not recognise the professional expectations of their role to participate in, respond to, and indeed, lead change as part of a ‘whole of nursing’ approach to education. According to Hall and Hord (2001, p. 7), one of the seeming paradoxes of organisational change is that:

Although everyone wants to talk about such broad concepts as policy, systems, and organisational factors, successful change starts and ends at the individual level. The entire organisation does not change until each member has changed.

Despite being expected to lead change, clinical nurse educators were unclear about intraprofessional role boundaries in relation to nursing education. It is widely recognised that irrespective of the change framework used, change involves creating and realising new behaviours, symbols and activities (Cannon and Lonsdale, 1987; Schein, 1992) and structural change does little to optimise health care teams as partnerships (Cooper et al., 2004).

While there has been considerable restructure within the nursing profession in Australia, there has been little recognition of the potential for this restructure to lead to role confusion and overlap among those who are required to facilitate change. During the workshops, the clinical nurse educators acknowledged they had been involved in limited discussion of their role in facilitating change in both individuals and organisations. These experiences are not isolated to this health service as it has long been observed that hospital-based nursing staff educators are rarely provided with opportunities to explore the paradigm shift in nursing education that has resulted in a focus on praxis rather than process or product and the related consequences for their role (Ford and Profetto-McGrath, 1994).

In order to assist clinical nurse educators to explore and articulate their role, a conceptual model for a whole of nursing approach to nurse education was proposed. Drawing on the earlier work of Harden and Crosby (2000), this model suggests that the 12 teaching roles they identified are undertaken by a range of categories of nurse in intraprofessional partnership (see Fig. 1).

This model was adopted by the clinical nurse educators as a framework within which they could identify their domains of practice and associated performance indicators. An intraprofessional partnership approach to nurses’ continuous professional development was considered optimal, recognising the contribution by each group to the overall quality of education. In seeking to establish and validate their own identity, the group clarified what each category of nurse brought to the education team. The group recognised there was some overlap among these but suggested as in Table 1.

The group also identified that nursing unit managers were part of the intraprofessional education partnership being well placed to advise on clinical practice and performance issues. It was agreed that they should have input into priority setting for education at unit level, while more senior nursing management (e.g. Directors of Nursing and Clinical Stream/Divisional Nurse Managers) facilitated education through securing and allocating resources and advising on the broader organisation strategic direction and profession-specific issues. Through the workshop activities, the clinical nurse

Figure 1  Teaching roles. Adapted from Harden and Crosby (2000).
educators recognised that of the above professional groupings their role alone had a primary emphasis on clinical education.

The role of the clinical nurse educator

Within this intraprofessional partnership model clinical nurse educators need a well defined identity that validates their roles in facilitating professional competence as well as task mastery of clinical skills. For more than a decade, literature relating to nurse education indicates that those who educate nurses should be encouraging the development of skills in critical thinking, problem solving and clinical reasoning for professional success (Brigham, 1993; Facione and Facione, 1996; Dale, 1994; Brookfield, 1993; Howenstein et al., 1996; Kelly, 1997). Nursing’s prevailing educational paradigm should therefore challenge nurses to question practice. The behaviourist influence has told nurses what to learn and believe (Whiteside, 1997), however, the trend in general education to view knowledge as constructed within personal and social constructs (Biggs and Telfer, 1987; Leder, 1993; Cranton, 1994; Mezirow, 1985), is increasingly being embraced by those who educate nurses and other health professional (Rose and Best, 2005).

During the workshops, the participants were facilitated through a process of identifying the domains of their practice as clinical educators and as nurses within an intraprofessional partnership. Analysis of the workshop data indicated that the clinical educators’ practice was consistent with the four inter-related roles of clinical education identified by Ullian (1986). These require being able to perform as:

• A clinician role model: the clinical nurse educator upholds professional standards; acts as a socializing agent and effective member of a professional discipline who is knowledgeable, competent, caring and professional.
• A teacher: the clinical nurse educator is involved in planning education, motivating learners and identifying learners’ needs in a given clinical context.
• A supervisor: the clinical nurse educator gives direction in patient care when required; provides feedback; involves and works with learners in providing clinical care.
• A support person: the clinical nurse educator engages in mentoring; showing an interest and providing advice about career planning in nursing.

As a result of the workshop activity it became apparent that the clinical nurse educators had developed individual strategies for managing daily work in response to others’ perceptions of their role and lacked a shared identity within which to shape their practice.

Table 1  Role clarification and associated responsibilities for nursing education

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<tr>
<th>Role</th>
<th>Description</th>
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<tr>
<td>Clinical nurse educators</td>
<td>Bring clinical expertise, capacity to support learners in the clinical settings using a range of strategies that are dependent on context (e.g. direct interaction with Trainee Enrolled Nurse/New Graduate Nurse or supporting others to support them, providing structure for and coordinating mandatory training)</td>
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<td>Clinical nurse consultants</td>
<td>Provide clinical expertise, data analysis of incidents, audits, research. They have the capacity to guide priority setting in education and knowledge of professional directions with regard to colleges, networks, other organisations, etc.</td>
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<tr>
<td>Clinical nurse specialists</td>
<td>Bring focused clinical expertise relevant to their specialty area of practice, currency of practice in direct patient care as well as support of their learners and peers</td>
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<tr>
<td>Nurse educators</td>
<td>Have instructional design and curriculum skills, ability to advise regarding outcomes of educational needs analysis process, evaluation experience, knowledge of education provider (e.g. university and TAFE) curricula, systems and processes, and an awareness of how Area wide initiatives impact on education</td>
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Note: These terms may not translate exactly to an international context but the descriptions of associated responsibilities for nurse education inherent within each role may assist the reader unfamiliar with the terminology used in NSW.
White and Ewan, 1991) and clinical competence (Mogan and Knox, 1987; Nehring, 1990; Sieh and Bell, 1994). While it has often been declared that the central role of the clinical teacher has been to act as a role model for other nurse (Betz, 1985; Kotzabassaki et al., 1997; Mogan and Knox,

<table>
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<tr>
<th>Domain</th>
<th>CNE role – Identified by</th>
<th>Demonstrated by</th>
<th>Evidenced by</th>
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<tbody>
<tr>
<td>CLINICAL TEACHING</td>
<td>The CNE uses creative and resourceful strategies/processes to contribute to a learning environment that supports flexible, learner centred opportunities</td>
<td>The CNE: • Uses a range of teaching/assessment strategies, in order to capture the needs of all learners. • Uses multiple approaches to gather data about the learner. • Relates legislative concepts to institutional policies and procedures • Acts to promote protection and safety of clients, self and others</td>
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<td>Assessing</td>
<td>Facilitates professional development and expertise through educational support and assessment of learners’ goals and clinical competency achievement</td>
<td>The CNE: • Provides opportunities for, and facilitates other staff to participate in assessment activities • Contributes relevant data in order to maintain databases • Provides formative and summative assessment for learners’ clinical practice • Demonstrates highly developed context specific assessment skills</td>
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<td>Communication</td>
<td>The CNE instigates, maintains &amp; uses collegial networks in a mature, confident &amp; assertive manner to achieve positive learning outcomes for clinical staff. The CNE communicates in a manner that is open, responsive, non judgemental, facilitative &amp; collegial. The CNE demonstrates accountability to all relevant stakeholders</td>
<td>The CNE: • Participates in and contributes to relevant meetings and working parties • Identifies and assesses learners’ needs through the use of a variety of formal and informal communication strategies • Maintains respectful and professional boundaries • Encourages learners to express fears or feelings and supports them in referral to other support mechanisms where appropriate • Participates in formal and informal feedback to learner regarding their practice.</td>
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<tr>
<td>Professional Role Model</td>
<td>The CNE instils confidence and trust in colleagues through demonstration of sensitivity to others. The CNE assumes responsibilities for teaching and facilitating functions, acting as a role model. Confidence in practice is evident in the CNE.</td>
<td>The CNE: • Establishes positive relationships with colleagues • Acts to support staff in stressful situations • Encourages participation in continuing education • Acts as a positive role model for colleagues • Assess learning needs of colleagues related to their scope of practice • Initiates strategies to promote the learning of colleagues and others</td>
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<tr>
<td>Enhances professional development</td>
<td>Demonstrates a commitment to ongoing professional development to maintain best practice</td>
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<td>Mentoring</td>
<td>The CNE engages in activities that demonstrate a commitment to ongoing professional development of self and others to maintain best practice</td>
<td>The CNE: • Fosters positive professional relationships • Seeks mentorship for their own professional development • Provides mentorship for others where appropriate • Regularly engages in the process of self-assessment • Uses the mentoring framework for self and others, to review progress towards career goals</td>
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Figure 2  The clinical nurse educator performance management tool.
of their role. It is apparent that the clinical nurse educators who engaged in the review of their roles and functions operate from educational frameworks that are consistent with leading enhanced professional practice through education. What is less apparent is the extent to which other stakeholders in nursing share this commitment to professional development (and the development of the profession) in an industrial climate which values clinical nurse educators maintaining their identity as expert clinicians and negates their educational expertise. There is a need to be vigilant against the erosion of the importance of formalised support for continuing professional development in clinical practice. Without work that clearly identifies the expectations and benefits of the hospital-based clinical educator in Australia, the potential remains for short term staffing needs to overwhelm the educational needs of clinical nursing staff as the clinical managers to whom these hospital-based clinical nurse educators report confront the day-to-day challenges of care delivery.

### References


