The Nurse Educator’s clinical role

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Aim. This paper reports a two-phase descriptive study exploring the clinical role of the nurse educator in Malta.

Background. Previous studies indicate a number of similarities and differences in the clinical role of nurse educators by country of practice. These include importance assigned to the role, factors inhibiting/facilitating the role, means to eliminate barriers to the role, and perceptions of the ideal role.

Design and methods. Data were collected using both quantitative and qualitative strategies. The quantitative phase involved asking all educators to fill in a time log of their academic and clinical activities for a 2-week period. In the qualitative phase, the first author interviewed five educators, five nurses and five students about their perceptions of factors which impact the nurse educator’s clinical role, as well as what the ideal clinical role of the nurse educator should be.

Findings. Maltese nurse educators allot minimal time to their clinical role. Main reasons cited included workload, perceived lack of control over the clinical area, and diminished clinical competence. Nurse educators who frequented the clinical settings (who were either university or joint university and health service employees) where the study took place perceived that employment inequities among the various categories of nurse educators played an important role in the amount of time dedicated by each group to their clinical roles, and the importance individuals in these groups assigned to that role. The majority of interviewees saw the current role of nurse educators in Malta as preparing students for successful completion of the didactic sections of their programme, rather than preparing them with all the knowledge and clinical skills necessary to be competent practitioners. Participants considered that, when in clinical areas, nurse educators did focus on their students, as they should. However, they also thought that they often did not take the opportunity to forge links with professional staff.

Conclusion. The clinical role of the Maltese nurse educator needs to be more multifaceted in approach.

Keywords: Nurse educator, role, perceptions, student nurses, staff nurses, role impact
Introduction

Amalgamation of nursing education into universities has raised many questions about the clinical role of nurse educators. A number of studies now show that nurse teachers have conflicting views about whether their priorities should lie in academia or in clinical credibility (Hindley 1997, Murray & Thomas 1998). Since the demands of higher education necessitate that educators spend more time in the classroom than in clinical areas, there is always a risk of teachers becoming better academically versed, but less clinically competent. In addition, as the academic side of the university nurse teacher role further evolves, the clinical role is likely to continue to be a contentious issue requiring further investigation.

In 1988, nursing education in Malta became integrated into the university and, within a short time, nurse educators began having problems with their clinical role, as this was not clearly defined at the time of integration. Since there were no previously documented studies of the nurse educator role in Malta, a study was carried out to determine the extent to which studies in other countries might be applicable to the Maltese situation.

Background

We became interested in exploring the clinical role of nurse educators because of a perception among a variety of people in the health care field in Malta, including many nurse educators themselves, that nurse educators were doing a poor job in fulfilling their clinical role. Although we were not entirely convinced that this perception was accurate, we did know that the literature suggested that it might be correct, given the situation in other countries. We found in the literature, for instance, that British authors such as Webster (1990) and Castledine (1993) were saying that nurse educators spend little time in clinical areas. However, we could find no solid research evidence either to support or refute these claims. Indeed, after examining a number of studies on the clinical role of nurse educators, we found many to be limited and inconclusive, because they did not use consistent measurements of either duration or frequency of visits of educators to clinical areas (Just et al. 1989, Clifford 1993, Forrest et al. 1996, Camiah 1998).

We found from examining a number of studies of the nurse educator’s role that studies of this topic were almost exclusively British or American in origin (Barger & Bridges, 1987, Cahill 1997, Clifford 1993, 1995, Camiah 1998, Just et al. 1989, Forrest et al. 1996, Day et al. 1998). Interestingly, an overview of these studies suggested that American nurse educators were more committed to their clinical roles than their British counterparts. However, we also realized that those British studies which we were able to examine were conducted for the most part before 1999, when the English National Board for Nursing, Midwifery and Health Visiting mandated that nurse educators in the United Kingdom (UK) spend 20% of their time in practice (Aston et al. 2000).

We found a number of factors in the literature to suggest why British and American nurse educators were finding it difficult to fulfill their clinical role. In Britain, the main factor identified by the nurse educators’ was lack of time, because of being overburdened with educational and administrative work and the need to conduct research and to publish (Clifford 1995, Cahill 1997, Day et al. 1998). In American studies, educators reported that they lacked time for their clinical role due to family responsibilities, and being enrolled in doctoral programmes (Barger and Bridges 1987, Just et al. 1989). The possibility of similarities and differences between Malta and these countries guided the design of our study.

The literature suggested a further interesting difference between British and American educators, which we needed to take into account. This was related to the specific types of activities in which nurse educators engaged when they were in clinical areas. The studies, just cited above, suggested that British educators tend to prefer liaison roles with clinical agencies, while their American counterparts tend to be more involved in direct clinical teaching and patient care. We could not find any data in the literature to suggest directly the reasons for this disparity between countries. We thought that it might be explained by the different evolutionary, professional and political changes that were occurring in nursing in both countries.

We also considered it noteworthy that none of the studies we examined included the views of other groups, such as students and staff nurses, as to their preferences about the educator’s clinical role. It seemed important, then, for our study to look at both the specific preferences of Maltese nurse educators in relation to their clinical role/activities, and the preferences of students and staff nurses.

The Maltese context

To fully appreciate this study and its findings requires some knowledge of the setting in which Maltese nurse educators practice, including the connection between nursing education in Malta and Britain. From its very inception, nursing education in Malta was modelled on the British system, due to the close historical connection between the countries. Indeed, some early nurse educators in Malta were British. As a result, the nurse educator role in these countries has evolved
similarly. In both Britain and Malta, nurses and ward sisters in the practice setting initially provided the clinical education for nursing students. The only difference between the early Maltese and British systems was that in Britain there were also clinical teachers, who were allotted to the wards to help ward sisters with their teaching role [Aston et al. 2000].

However, in the mid-1980s the clinical teacher was eliminated, and nurse educators were left with no clearly defined clinical role [Humphreys et al. 2000]. This lack of definition led to role confusion. In Malta, integration of nursing education into the university happened in 1988, and role confusion also occurred as the clinical role here too went largely undefined. In 1995, in an effort to clear some of the confusion, the English National Board for Nursing, Midwifery and Health Visiting advised that British nurse educators must spend 20% of their time in clinical areas [Aston et al. 2000]. In Malta, nurse educators were also expected to supervise students clinically, but no percentage of time was specified.

Both diploma and degree nursing programmes in Malta are fully integrated into the university. Prior to integration into the university, none of the nurse educators’ in Malta had an undergraduate degree. For this reason, the first degree programme was set up by British educators from the University of Liverpool, and its curriculum was based on theirs. At the time of the study reported here, this curriculum remained, monitored by British external examiners, and there were 22 nurse educators. Of these, most (n = 19), either had a degree or were well on the way to getting one: one had a baccalaureate degree, 10 were pursuing a Master’s degree, six had a Master’s degree (n = 6), one had a doctoral degree (n = 1), and one was pursuing a doctoral degree.

The study

Aim

The broad aim of the study was to explore the clinical role of nurse educators in Malta. Specifically, the study sought to identify:

- The nature and extent of the nurse educator’s involvement in the clinical area.
- The perceptions of various individuals working in the health field in Malta (i.e. nurse educators, staff nurses in clinical settings and student nurses) about which factors facilitate, and which inhibit the nurse educator in her/his clinical role.
- The perception of various individuals working in the health field in Malta (i.e. nurse educators, staff nurses in clinical settings, and student nurses) about the ideal clinical role for the nurse educator.

Design

The study was conducted in two phases. The first phase was quantitative and was designed to investigate the nature of nurse educators’ work and clinical involvement. The second stage was qualitative and was designed to identify factors, which might inhibit or facilitate the educator role in the clinical area, and to explore respondents’ perceptions of what nurse educators should be doing there.

Methods

Quantitative phase

A major deficit of earlier studies was that they failed to measure precisely the amount of time educators spend in the clinical area [Lee 1996]. Therefore, all available nurse educators in Malta (n = 22) were asked to complete, over a 2-week period, time logs to record daily all their work activities, including work carried out at home. Twenty-two time logs were handed out to the total available population of nurse educators, and 17 were returned, giving a response rate of 73%. One time log was not filled in properly, and was discarded.

Qualitative phase

As the inclusion of the opinions of clinicians and students on the educator’s clinical role was a neglected area in most previous research [Clifford 1993, 1997, Crotty 1993a, 1993b, Baillie 1994], data for this study were collected from a convenience sample of educators (n = 5), clinicians (n = 5) and students (n = 5).

These data were collected using taped semi-structured interviews conducted by the first author (OG). The interview schedules used by Forrest et al. (1996) and Day et al. (1998) informed the design of the interview, which was composed of open-ended questions about the following aspects:

- educators’ clinical involvement and the nature of their clinical work;
- factors inhibiting/facilitating performance of the clinical role;
- the ideal role of educators in clinical areas.

The questions were tested in a pilot study involving two educators, two clinicians, and two students. The interviews were conducted over a 3-week period, and after the time logs were compiled, to decrease the influence the latter might have on interviewees responses. The duration of the interviews

O. Griscti et al.

varied from 15 to 60 minutes, and were held in the workplace.

Ethical considerations
A Board of Studies Committee, responsible for ethical reviews at the educational institute where the study took place, gave this study ethical approval. Study participants were told of the measures which maintain anonymity and confidentiality in relation to their interview data (e.g. identity and data codes, secure area for interview data). Participants were also asked to place their time log records, free of any identifying information, in a sealed box in the reception area of the institution where the study took place.

Data analysis
Time logs were analysed using both descriptive and inferential statistics. In order to get a broader picture of workloads, repeated measures ANOVA analysis was used to identify differences in the reported amount of time spent on preparation and teaching, assignment marking, academic counselling, and clinical supervision.

Interview data were subjected to the techniques of thematic analysis (Riley 1996).

Findings
The thematic analysis of interview data revealed six main factors, which seemed to impact the clinical role performance of nurse educators: juggling work, equity of work conditions, an element of control, safe in the classroom, for the final exam and espousing theory and practice. These themes will be discussed alongside the quantitative data, and the following codes will be used: E, nurse educator; S, student nurse; and RN, staff nurse.

Table 1 Nature of the Nurse Educator’s Activities

<table>
<thead>
<tr>
<th>Weekly teaching and lecture preparation hours</th>
<th>n</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly student’s academic supervision and assessments</td>
<td>16</td>
<td>4</td>
<td>21</td>
<td>10.5938</td>
<td>4.473</td>
</tr>
<tr>
<td>Weekly administration and coordination hours</td>
<td>16</td>
<td>0</td>
<td>16</td>
<td>5.4063</td>
<td>2.352</td>
</tr>
<tr>
<td>Weekly professional development hours</td>
<td>16</td>
<td>0</td>
<td>21</td>
<td>4.5938</td>
<td>4.9133</td>
</tr>
<tr>
<td>Weekly clinical activities hours</td>
<td>16</td>
<td>0</td>
<td>17</td>
<td>2.5312</td>
<td>2.7837</td>
</tr>
<tr>
<td>Weekly meeting hours</td>
<td>16</td>
<td>0</td>
<td>7.5</td>
<td>2.5</td>
<td>2.1602</td>
</tr>
<tr>
<td>Weekly hours devoted to other matters</td>
<td>16</td>
<td>0</td>
<td>7.5</td>
<td>1.375</td>
<td>2.7719</td>
</tr>
<tr>
<td>Total weekly hours</td>
<td>16</td>
<td>23</td>
<td>62.5</td>
<td>41</td>
<td>10.1653</td>
</tr>
</tbody>
</table>

Juggling work
The conclusion that this factor impinged on the clinical role of educators emerged from interview descriptions of the juggling efforts which they made to find time to fulfil their various roles because of time and workload issues:

less workload from the institute’s part, because it is difficult to juggle between the work here and going to the clinical area. (E 1)

Time log data also revealed that the amount of time educators spent on their work was approximately 40 hours/week (mean 41 hours) (see Table 1). The SD was, however, large (SD 10-17), and the working hours for 95% ranged from 20.6 to 61.4 hours/week. It is possible, therefore, that those who commented on time constraints in the interviews were the ones who worked the most hours. This possibility cannot be confirmed, however, because the time logs were anonymous.

Time log data also revealed that lecture preparation and classroom teaching were the activities, which took up the most time (mean 14 hours or 34-1% of the mean number of working hours per week). Other tasks that ranked highly were the weekly supervision and assessment hours for student assignments (mean 10.6 hours or 25.9% of the mean number of working hours per week). This is quite different from British reports such as that of Gallego et al. (1980) and Nolan (1987), where the mean amount of time for marking students’ work was 4.8 hours/week (13% of all educator’s activities) in both studies and between 1.5 and 7.5 hours (3.6–13.5% of all educator’s activities) per week, respectively. A possible explanation for the discrepancy is that these studies were conducted some time ago, prior to integration of British nursing programmes into universities. The discrepancy might also have occurred because our time logs were inadvertently carried out during an atypical period of the year, when students were doing many assignments and dissertations were being marked.
It appears that non-academic work, such as administration and co-ordination occupy a large proportion of nurse educator time in Malta (mean \(M = 5.4\), \(SD = 5.23\)) (see Table 1). This is of particular concern, because it highlights that some educators are doing work not necessarily related to their professional roles:

what happened these past few years, secretarial support was reduced so we ended up doing most of the clerical work ourselves. (E 1)

The fact that this educator was one of the course coordinators in the programme, however, might explain this amount of clerical work. As one coordinator also filled in the time logs, the mean hours for administrative and coordination work may also have been inflated.

Not surprisingly, all the educators interviewed (\(n = 5\)) felt that the clinical role was an important aspect of their work. Educators used phrases like 'hand in hand' (E4), 'running parallel' (E2), and 'interlinked' (E3) to describe the importance of clinical vs. classroom teaching. Despite these stated beliefs about the importance of the clinical role, time logs (see Table 1) revealed that respondents spent less time in clinical areas than in classrooms, a seeming contradiction. Table 2, however, may provide a possible explanation for this, as it shows that there was a significant difference among participants in the amount of time spent on different aspects of the workload. Specifically, there was a statistically significant difference (\(P < 0.05\)) in the amount of time devoted to course preparation and didactic delivery, academic counselling and marking, and direct clinical supervision. While the reason(s) for these variations in workload cannot be identified with certainty, given the nature of the data collected, they may well relate to the juggling efforts that educators said they had to make to find time for their clinical role.

Most of the above results support trends identified in previous British studies (Sheahan 1981, Clifford 1996). The value placed on the clinical role by nurse educators in both countries is but one of those. However, it is also important to note that not all our results matched those found in British studies. For example, Table 1 shows that 53% of Maltese nurse educators visited the clinical areas. Although this figure was lower than we would have liked, it was higher than that in British studies by Clifford (1993), and Clifford (1995), where the percentages of educators who visited the clinical areas were 42.5% and 26.6% respectively.

There are a number of possible explanations for the attendance differences, including the fact that the British studies were conducted some 4–6 years before ours might help explain the discrepancy. There has been increasing emphasis on the clinical role in Britain in recent years (Aston et al. 2000, Humphreys et al. 2000), which might cause different results were we to conduct studies like these in Britain now. Also, it is possible that the discrepancy may have occurred because of some difference that we were unable to identify among the clinical supervision models used by the nursing programmes in these studies. However, we cannot eliminate the possibility that the differences might be the result of some yet to be identified cultural difference between educators in these two countries, and we would be interested in pursuing this possibility in a future study.

Equity of working conditions

One factor identified as impinging on the clinical role was the perceptions by all the Maltese educators interviewed (\(n = 5\)) of inequities among them, one of which was financial in nature. This inequity apparently occurs because nurse edu-

<table>
<thead>
<tr>
<th>Reference activity</th>
<th>Comparative activity</th>
<th>Mean difference</th>
<th>SE</th>
<th>Significance</th>
<th>95% Confidence Interval for difference(^{1})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching</td>
<td>Support</td>
<td>2.906(^{*})</td>
<td>0.810</td>
<td>0.008</td>
<td>0.723 – 5.089</td>
</tr>
<tr>
<td></td>
<td>Clinical</td>
<td>11.281(^{*})</td>
<td>1.037</td>
<td>&lt;0.001</td>
<td>8.488 – 14.074</td>
</tr>
<tr>
<td>Support</td>
<td>Teaching</td>
<td>-2.906(^{*})</td>
<td>0.810</td>
<td>0.008</td>
<td>-5.089 – -0.723</td>
</tr>
<tr>
<td></td>
<td>Clinical</td>
<td>8.375(^{*})</td>
<td>1.219</td>
<td>&lt;0.001</td>
<td>5.091 – 11.659</td>
</tr>
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<td>Teaching</td>
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<td>&lt;0.001</td>
<td>-11.659 – -5.091</td>
</tr>
</tbody>
</table>

\(^{1}\)The mean difference is significant at the 0.05 level.

\(^{1}\)Adjustment for multiple comparisons: Bonferroni.
Cators in Malta are employed either by the university or have a dual appointment with the university and the Department of Health. That those from the university group receive less payment than those with a joint appointment is a widely held belief:

It’s a question of who is with the educational institute, who has a joint appointment (referring to staff employed by the Department of Health and University). Who is getting one pay, who is getting two salaries. So, it’s all a question of who’s doing what, for how much. (E 4)

It should be no surprise that financial concerns would be an important factor influencing whether Maltese educators go to clinical areas, since it was found to be important in other countries such as America (Dickens 1983, Just et al. 1989). Indeed, the interviews revealed that the educators (n = 2) who most frequented the clinical area were those with dual appointments, and presumably better salaries. However, the interviews also revealed that those working for the University alone (n = 3) paid fewer visits to the clinical area for reasons possibly other than salary. All three said that they did not have legal cover to work in clinical areas, while dual appointees did. In addition, as in Clifford (1996), we found that those (n = 3) who visited the clinical area less frequently (i.e. the university employed) had been in the educational field far longer than their dual appointed counterparts (n = 2). Time in the field, then, may also help explain why the university appointees did not attend clinical as frequently as dual appointees.

An element of control

We found that some factors which impinge on the nurse educators’ clinical role arise from the stress of teaching in the clinical area. Such stress has been identified as coming from many sources, a common one being lack of control over the clinical situation (Quinn 1995).

One of the most common fears expressed by a number of educators (n = 4) was that they felt threatened by the near-perfect performance expected of them by clinical staff and students, and by the fact that they were expected to know everything about the care of patients with multiple problems:

Discouraging also is obviously the strain of it, I mean its quite stressful to be in this situation, because you know that emm...any mistake which you make in the morning is going to be amplified more, being a member of staff of the institute and being a teacher sort of, you are expected to perform well. So that obviously is discouraging knowing that you are not only under the eyes of the students but also the staff on the wards, so that anything which you do wrong sort of, will be obviously frowned upon more that if it is a member of staff. (E 2)

Educators felt that one way to reduce this fear of uncertainty and lack of control would be to allow them to practice in their area of specialty. Indeed, all those interviewed (n = 5) perceived practising in their specialty area as a motivator for them to go to clinical areas. They felt this was important, because it would make them feel ‘comfortable’ (E 2), ‘at home’ (E 4), ‘not anxious’ (E 2). This finding is supported by the findings of Carlisle et al. (1997) that educators felt little motivation to visit the clinical area in which they had no expertise.

The structuring of clinical visits, ability to choose students’ patients, and support from clinicians were cited by most educators (n = 4) as providing them with the element of control they needed in the clinical area. One commented that it is very important to have a good relationship with staff, not only for negotiations but also for support in event of difficulties:

with whom you’re working, where you’re working, what type of patients you’re working with...It gives you an element of control sort of, it gives you an element of comfort so to speak. (E 2)

Safe in the classroom

Some of the educators interviewed (n = 3) thought that there was a noticeable degree of variation in clinical competence between them. Nurses from the clinical area (n = 4) and students (n = 3) also commented on differences in competence among educators. Some educators (n = 3) reported that variations in competence resulted in their opting to stay ‘safe in the classroom’, rather than going to the clinical area.

It was evident that those educators (n = 2) who kept regular contact with the clinical area (i.e. the dual appointees) felt quite competent. They had confidence in their skills, and reported experiencing minimal anxiety in the clinical area. They also felt that going to the clinical area was in itself a motivating factor, because it helped them to maintain their clinical skills. In previous studies in both Britain and America, maintenance of clinical skills was also found to be one of the motivating factors for educators to frequent clinical areas (Just et al. 1989, Clifford 1992).

On the other hand, educators (n = 3) who had not gone to the clinical area in recent years (i.e. university appointees) seemed quite apprehensive about going there:

I would love to go up to the clinical area. emmm, its very much needed, as I have said before, but I think I’ve become too much...
nowadays, sort of safe...either in the classroom or in supervising academic work. (E 5)

All three of these educators felt that they lacked the necessary clinical skills to cope, because of the continuing changes in practice areas. One showed apprehension about not being familiar with the layout of the clinical area, its practices and the documentation used, and other attendant factors.

A very important finding was that participants felt that clinical competence could be regained. Most of the educators \((n = 5)\), nurses \((n = 3)\), and students \((n = 3)\) interviewed seemed convinced that educators would be able to regain their skills if they were to visit the clinical area more often. One nurse acknowledged that:

Once you have lost touch with the ward and have not been working in the ward for a long time, you know it can happen to anyone, you’ll find it difficult to start. (RN 1)

Both educators who did and those who did not frequent the clinical areas used comments such as ‘rusty at first’ (E 2), ‘they (her skills) need a brush’ (E 5), ‘if I am given a couple of days I would get used to these things’ (E 4) to express their need for more practice.

For the final clinical exam

All the educators interviewed \((n = 5)\) said that they did visit the clinical area. However, most of the study participants \((n = 13)\) noted a potential concern related to these clinical visits. Staff nurses \((n = 5)\), students \((n = 5)\), and university appointed educators \((n = 3)\) said that the educators usually only visited the clinical area to supervise and assess students for their final clinical examination. All \((n = 15)\) also said, that when educators did visit the clinical area, that they usually did so for approximately 5 hours. One nurse summed it up by saying:

Before the exams they work with each student, they spend three mornings with him, working together. Naturally they (educators) base their practice, gear it more towards the exam. They take care of four patients and spend the morning doing things as they should be...for the exams, more than reality...to pass the exam Heh! Heh!...at least that’s the way I feel. (RN 5)

These findings, however, must be viewed with caution. The perception that clinical supervision of students in Malta is solely examination-oriented may not be totally accurate. Two educators interviewed (i.e. the dual appointees) specifically mentioned that they also supervised and assessed students for other reasons. In addition, the students interviewed were all final year students, and this particular cohort did not receive as much supervision as more recent cohorts.

Espousing theory and practice

The final factor identified as impacting on the clinical role was labelled ‘espousing theory and practice’. The label for this factor derives from what participants thought the ideal clinical role of the nurse educator should be. When asked what they perceived as the ideal role for a nurse educator in the clinical area two categories emerged, one being the educator as a clinical teacher, and the other as a facilitator of the learning environment through various roles with staff in clinical areas (e.g. liaison, updating staff, social chats).

In British studies, the preferred roles for educators with clinical staff were found to be those of liaison (Crotty 1993a, 1993b, Camiah 1998), social chats (Clifford 1993, Baillie 1994), and supporting staff in updating themselves (Clifford 1993, Carlisle et al. 1997). Overall, our findings were that all participants \((n = 15)\) saw some role for educators with clinical staff. One nurse commented:

I feel that the Institute is too much isolated...It’s them up there and us here. We are not talking on equal terms I’m afraid...we are too much isolated. (RN 4)

A nurse educator remarked:

We hardly link with the people up there (pointing to the hospital), not even for a simple lunch or a get together...doesn’t necessarily mean a conference or whatever. (E 4)

All \((n = 15)\) felt that liaison with clinical staff would be a very useful way to increase cooperation between the clinical areas and the educational institute. All \((n = 15)\) also felt that social chats with staff would be useful. Some specifically commented that it would help prevent an ‘us and them attitude’ (E 2), that it would ‘encourage educators to come down from the throne’ (S 1), thereby helping to confirm that ‘educators are not strangers’ (S 1) and preventing people from thinking that ‘we are in an ivory tower’ (E 5).

Although the educators interviewed \((n = 5)\) said that they saw helping clinical staff to update their skills as important, they seemed to concentrate most of their effort on students. It would appear, therefore, that there might be a need to formalize the educator’s role in Malta to ensure that the role with clinical staff gets the emphasis it should. When the educators \((n = 5)\) were asked if they believed that they should have a formalized clinical role, most \((n = 4)\) agreed. One disagreed, however, because she felt that some educators were not comfortable going to the clinical area. In addition, some who agreed \((n = 3)\) said that they would do so only if certain conditions were established beforehand. One respondent’s answer sums up some of these preset conditions as
I think it should be formalised, I think it’s quite informal at the moment, sort of everybody chooses what they want to do. But I think, yes, it should be formalised because it should be viewed as an obligation for everyone to take this role, provided that you have to make sure that they feel comfortable, that they are prepared, that they feel competent. (E 2)

Conclusions

Nursing in Malta, like everywhere else in the world, is not as valued as other disciplines such as medicine often are. Therefore, local lobbying to address the kinds of issues, which this study suggests nurse educators must daily face has not always been that effective. Because this study showed that the issues faced by Maltese nurse educators are not so very different from those faced by nurse educators worldwide, we consider that its findings underscore the need for the nursing organizations internationally to work more closely together. Specifically, we believe that our study suggests the need for these organizations to work together more closely to create a powerful lobby, to bring to international attention the issues faced not only by nurse educators in small countries like Malta, but also by nurse educators in other countries across the world. Only such international action can bring such issues to the attention of local governments, and help bring about needed changes.

Our findings, like those of studies in other countries, suggest that there is already a cultural ethos among nurse educators which would support the adoption of a more multifaceted clinical role should barriers to its adoption be removed. This study, also like those in others countries, indicates that one of the most important barriers to Maltese nurse educators fulfilling such a multifaceted role is lack of time. These findings, taken in concert with the current worldwide shortage of nurse educators, should lead to the conclusion that the problem of lack of time can only get worse. This should certainly again underscore the need for nursing organizations to create the more powerful international lobby for which we are advocating.

Acknowledgements

We would like to thank the nurse tutors, nurses, and students who participated in the study. We would also like to thank Epifanio Ciantar who assisted in establishing auditability.

Author contributions

Data analysis/Critical revisions of manuscript/Administrative support – OG, BJ, JJ; Study conception and design/Drafting of manuscript – OG, BJ; Supervision – BJ, JJ; Statistical expertise – JJ; Data collection – OG.

References


