# Teaching the ideas of others: Is there a problem?

**Abstract**

University nurse educators do not always possess subject expertise in the non-nursing disciplines from which the ideas they use in teaching are derived. This is potentially problematic. Subject expertise can be variously defined. Nonetheless, expertise is associated with education, and education is often assessed by processes culminating in accreditation. Nurse educators, however, do not hold first degrees in every subject they take ideas from (i.e., biology, ethics, pharmacology, philosophy, psychology, sociology, *etcetera*), and in consequence ideas are brought to the attention of students studying for first and higher degrees by educators who lack accreditation at the level at which the ideas they use in teaching are taken. Disjuncture's between accredited learning and teaching generate epistemological and other conundrums. Nevertheless, bluntly, absent subject expertise, educators risk talking nonsense when poorly understood ideas are presented to students.

**Paper**

University based nurse educators introduce students to ideas that have their genesis in non-nursing disciplines (e.g., biology, ethics, pharmacology, philosophy, psychology, sociology, *etcetera*.). These ideas are, on occasion, transformed during or following migration into nursing. When this happens, while an idea may retain the same descriptor, the meaning it comes to carry in nursing no longer matches that assumed in the originating discipline. "Phenomenology" might be an example of this. Arguably, in nursing, some forms of phenomenology either have or are becoming something other than identically named research and scholarship conducted outside nursing. Transformed or transforming ideas of this type are not discussed here. Instead, problems attending the use of ideas that continue to signal referents derived from non-nursing disciplines are explored. Specifically, it is proposed that when nurse educators use ideas obtained from non-nursing disciplines in teaching, if subject expertise is required to understand ideas at levels corresponding to or commensurate with university instruction, and if expertise is associated with accredited learning, where enlisted ideas maintain their original meanings (i.e. original according to the home discipline), nurse educators who lack first degrees in the subjects they take ideas from may utilise ideas in teaching they do not adequately comprehend. To make sense of this somewhat convoluted and tautological claim I draw on personal experience.

**Then and now**

A great deal of joy accompanied my student days. However, university life proved disappointing. By example, at some point we were introduced to Talcott Parsons' concept of the sick role. A hand goes up and a question is posed. At this distance I cannot remember what was asked. I do recall what followed. Our tutor became exasperated. She was reading off slides provided by someone else. She could not respond to inquiries about the content being delivered, and she was cross at being interrupted. This, I thought, was not education worthy of the name and since several people made excuses and left, others presumably reached the same conclusion.

Jump forward thirty plus years. I now work in education and one of my colleagues is introducing first year undergraduate students to the concept of holism.[1] That is, crudely, the idea that nurses need to consider more than the disease or physiological problem patients' present with. To this end, and to facilitate action in the world, my colleague breaks the holistic ideal down into four "domains". Each domain (physical, psychological, social, spiritual) provides a focus for care, and if nurses address these domains holistic care will – students are informed – be delivered.[2] For understandable reasons (these are first year students) explanation is simplified. Yet perhaps simplification also signals the terminus of educator comprehension?

Student questions are not precisely articulated, nonetheless, comments lead me to presume some of those present have studied sociology and psychology before. A subgroup is certainly aware that, for example, different conceptions of society exist, and enquires are made about bottom-up social theories (i.e., society emanates from or describes aggregated individual behaviour), top-down theories (society possesses *sui generis* powers that impose upon or direct individual behaviour), and elisionary theories (society emerges through the interplay of people and 'parts'). Within the context of the lecture questions about these differences make sense since "what society is" potentially impacts upon the nature of care delivered (as outlined by the educator). Alternatively, another student requests clarification of the concept culture (a notoriously difficult idea to define), and culture's links with ethnicity (an equally slippery notion). This connection was made in teaching. However, in each instance the educator does not seem to realise what is asked. Her understanding of society and "the social" appears limited. She cannot unpack or discuss how different ideas about society allow contrasting notions of holistic nursing care to be articulated, and in commenting on culture, she runs perilously close to advancing ill-considered generalisations about ethnicity and otherness. Holism's domains were also presented in teaching as distinct entities. Yet one student

[1] Neither key example employed in this paper identifies my current institution.
[2] Other conceptualisations of holism exist.

notes this contradicts earlier instruction where mental and physical health relations were intertwined. Can elaboration be offered? It cannot. Further, what conception of psychology is being discussed? Who knows? Lastly, enquiries are made about spirituality's remit and the extent to which spirituality overlaps with or can be differentiated from religion. What precisely is spirituality? What is religion? It isn't necessary to attend university to appreciate these are tricky concepts. Nonetheless, definitional questions demand attention when, for example, nurses are enjoined to address spirituality as a feature of holistic care. But at this point time is called. The session is closed. Off you go. No more chatter.

Holism requires that nurses understand "domains" of ideas with non-nursing referents. Yet this vignette describes an instance of teaching in which ideas were brought to the classroom by an educator who was unable to discuss these referents. My colleague asserted – entirely properly – that nurse's ought to consider how patients and their families are situated in society, and when sensible/pertinent, this consideration should inform care. My colleague lacked; however, an appreciation of sociology/social theory and she was therefore, bar platitudes, unable to speak meaningfully about society or the social. This scuppered her ability to give substance to the otherwise valid point made and, likewise, claims that nurses should heed patient psychology and spiritual wellbeing were revealed as similarly vacuous. Beyond banalities, and regardless of the need to make ideas accessible to first year students, explanation commensurate with degree level university education was, in my view, absent from teaching. Positively, my colleague was polite and cheery. I suspect students "like" her. Yet almost every inquiry remained unanswered, and I wonder what lesson students drew from these interchanges.

Another occasion, another day, a different colleague is preparing to deliver a lecture to either second- or third-year students (I forget which) on, among other things, aspects of health promotion. For whatever reason we start discussing content and I discover she intends to employ statistics reporting relative but not absolute risk ratios in her teaching. That seems odd.

What emerges in conversation is that, despite having taught health promotion for several years, my colleague has not heard about absolute risk, she is not concerned about this knowledge deficit, and she certainly does not think the topic worth worrying about. I disagree. I explain the difference between relative and absolute risk, and I stress why I think both ratios ought to be brought to the attention of students. My colleague, however, is adamant. Only relative risk ratios will be

referenced, and this is appropriate, she asserts, because the scary or dramatic nature of these statistics will impress upon students the message being conveyed (see Lipscomb, 2021).

In contrast to the holism exemplar which illustrated merely an absence of knowledge, this example is more complex. Not only was my colleague initially unaware of a vital element in what was being taught, we also here encounter differences in how nursing is conceptualised, and since both protagonists (she and me) work in education, these differences are manifest in the way teaching's telos or end point is positioned.

My colleague, underlining the nursing component of the nurse-educator role sought through her teaching to encourage behaviour commensurate with health, and if using relative but not absolute risk data facilitates this, so be it. Ends justify means, and promoting healthy behaviour meets her conception of what nurses do/should do. I also support the promotion of healthy behaviour. Who doesn't? However, I am concerned that in pursuing her aim my colleague withholds information (first unwittingly, then wittingly) that would prepare students (later nurses) to fully understand and thereby meaningfully help patients make informed choices about their care. She did what she did because she believes she knows what is in the interests of others. Sometimes we do and/or sometimes we must act for others. Yet employing relative risk figures because they "best make the point" is arguably manipulative. My colleague purposefully uses the psychological power inherent in relative risk data to get students and through them patients to act as she sees fit, and she does this because encouraging students and patients to abandon risky behaviours is, for her, the correct endpoint of teaching. This is not an ignoble aim. However, making behavioural change the primary goal of tuition is curious insofar as this performative conception differs from the way university education is usually thought about.

While nursing's practice focus complicates the following statement, normally, ideally, university educators teach theory so that, consequent to the educative experience, students are knowledgeable about or capable of engaging with ideas hitherto not understood. Here the emphasis is on knowledge and insight rather than behaviour or, we might add, the enculturation of sanctioned (settled) value commitments. Thus, although understanding may prompt action and/or the entertaining of values and ideas previously discounted, facilitating understanding does not aim at – and success is not measured against – tutees conforming with or meeting predetermined actions and/or accepting evaluative-normative conclusions. These comments simplify and generalise. Nevertheless, whilst the point made is inelegantly expressed, it is easily

grasped. Explicitly, a distinction is drawn between teaching focused on getting students to do or think things meeting preordained outcomes and teaching focused on forms of comprehension that do not necessarily require practical or concrete instantiation in prescribed action/belief.

Contra my colleague, I embrace this second (sketched) conceptualisation of education. My interpretation of professionalism leads me to emphasise nursing's need for *knowledgeable doers*, and although both parts of this phrase matter, the key word here is knowledgeable. Thus, within institutes of higher education, and when theory rather than skills teaching is considered, it may be useful to distinguish between the roles of nurse and educator (Lipscomb, *in press*). This bifurcation permits me to bring ideas into the classroom which might be considered antithetical to – in this instance – health promotion, where promotion just means encouraging healthy behaviour.

For example, had I delivered my colleague's lecture, I would begin by asking students to consider whether they think autonomy is important. If they do, and having appraised students about how relative and absolute risk ratios contribute to understanding, I would suggest that withholding information that enables informed and autonomous decision making (e.g., absolute risk data) is paternalistic. Of course, arguments favouring paternalism exist. Yet paternalism discounts autonomy, and if this is a value students respect, they should consider presenting both forms of statistic to patients even if presentation leads patients to decide they will continue to practice unhealthy behaviours. That is their choice. It is not ours to make for them or 'trick' them into.

My colleague and I have different views on the goal or objective of education (of nursing) and this difference, in part, reflects or instantiates contrasting judgements about autonomy and health. Identifying these differences has explanatory power and I return to this disjuncture in the conclusion. However, absent agreed metrics for arbitration or adjudication, this disagreement cannot be concluded. We both think we are right, and reasoned and reasonable arguments can be mustered to support each position. Accepting this impasse, I pivot critique back to epistemic considerations. As will become clear, although these considerations are evaluative (and it is important to recognise this), if the epistemic or knowledge-based challenge I present 'stands', a wider family of problems emerge. That is, wider than the instances outlined here.

**Epistemic (in)competence**

Thirty plus years ago whoever it was that introduced us to the sick role could not, I presume, situate this concept within functionalism (Parsons' theoretical framework). She certainly couldn't

discuss the evolution of this or kindred ideas (the sick role was postulated in 1951 and criticised almost immediately), and I take it she was unable to locate functionalism or the sick role against or alongside relevant alternative theories. When asked questions she could not answer she therefore shut questioning down. This person did not understand her subject matter. She should not have attempted to teach the subject. She was epistemically incompetent, and it showed.

Today, from the perspective of an educator rather than a student, I am concerned that witnessed first-year instruction about holism was deficient if sufficiency requires that legitimate and pertinent (clarificatory) questions be addressed. Further, regards health promotion, I believe students are not provided with the information (relative and absolute risk ratios) they need if they are to adequately (fairly) advise and assist patients comprehend and make educated choices about the risks they face. (This was the formal/stated but not enacted aim of teaching.) Crucially, putting aside questions about the telos of teaching, prior to our conversation my colleague was unaware of absolute risk and/or the difference between relative and absolute risk. Hence, if knowledge of these statistical measures is a necessary prerequisite for teaching statistically loaded subjects such as health promotion at degree level (i.e., in a programme of study leading to the award of a degree), in advance of our discussion my colleague lacked epistemic competence.

At a minimum, educators need to grasp the non-trivial features of whatever it is they are talking about at a level corresponding to or above what is taught. This blandly anodyne statement states the obvious. It should be uncontroversial. Yet "at a level" hints at problems demanding attention.

Introductions to holism, even for first year students, require that educators be prepared and able to respond to foreseeable relevant questions. And since subjects such as health promotion rely upon and utilise statistics, educators who lack adequate statistical acumen perforce do not grasp what it is they are teaching. The word "adequate" is question begging when used in this context. Even so, while determining how much and what should be known about the subjects we teach is not straightforward, and legitimate disagreement will be encountered when this is discussed, the knowledge base of my colleagues in the examples used here was arguably inadequate. If these were one-off events nothing much would hang on them. However, they are not. Another colleague, misunderstanding survivor bias, recently made confused and inaccurate statements to students regards the hospitalisation of double (fully) vaccinated Covid patients, and other examples could be cited.

**What ought we to know?**

All viewpoints come from somewhere and my perspective is both subjective and UK-centric. Moreover, I am primarily involved in under- rather than post-graduate education. Nonetheless, the problem being signalled defies parochialism and it runs beyond shortfalls in knowledge concerning holism and statistics. Thus, on a bigger canvas, given the range of subjects nurses legitimately and sensibly interest themselves in, educators necessarily bring to teaching ideas appropriated from a broad array of non-nursing disciplines. However, in this sequestration, nurse educators rarely possess subject expertise if by expertise we mean formal training/education to first degree level in the disciplines the ideas they use come from, and potentially this puts them in an invidious position when co-opted ideas are let loose in the classroom. Put plainly, just as, when I was a student my tutor introduced a concept she couldn't speak to (the sick role), and just as today colleagues lack what might reasonably be considered relevant knowledge (regards aspects of holism and statistics), nurse educators could be accused of using ideas in teaching they don't sufficiently understand. This is a serious charge.

The link made between accreditation (having a first degree) and acceptable knowledge/understanding can be contested. Yet many of the disciplines we rifle for ideas possess extensive hinterlands of developed and evolving thought. Nurses who lack subject expertise in these disciplines are unlikely to be familiar with these hinterlands, and colleagues who, in their teaching, utilise concepts taken from non-nursing disciplines (and who doesn't?) may not be able to provide contextualisation for the ideas they employ. In the classroom students are not then told how concepts brought to their attention were developed or received in the originating disciplines (the educator does not know). Students are not told how cited ideas have been critiqued or superseded (educators do not know), and students cannot be told whether the introduced concept is the most salient or up-to-date iteration of thinking in the home discipline (educators do not know).

Insofar as this contextualisation concerns non-nursing disciplines it might be tempting to say, "so what?" However, absent this knowledge, many ideas introduced in teaching cannot, when they come from non-nursing sources, carry meaningful scrutiny. And if students question educators about what is being said it is hardly surprising that today, as before, educators must conclude discussion. What else can they do? They have nothing else to say.

**Too harsh?**

Modern nurse education is vastly improved on that visited on past generations. None of my colleagues would speak to students in the way we were occasionally spoken to, and graduates exit knowing more, and they are better equipped to practice their craft than ever before. These positive changes merit considerable applause.

And yet, it is difficult to imagine encountering a university-based biology, ethics, pharmacology, philosophy, psychology, or sociology lecturer who did not themselves have a higher degree in the subject being taught. Oftentimes this degree will be a doctorate and, generally, many if not all of these tutors will be active researchers/scholars in their respective disciplines. They will be immersed in the ongoing debates and controversies that subject specialism signifies. They will be experts. That is why they are employed by universities.

Nurse educators, by comparison, often teach across a spectrum of subjects. What does this mean? It means nurse educators find themselves members of module teams with diverse aims/goals, and it means that even within "a" module the subject matter engaged often spans multiple fields – but – notably, nurse educators teach without holding subject specific first degrees in the disciplines the ideas they use come from. Nurses employed in higher education have clinical experience to draw on (a form of knowledge that quickly ossifies away from practice), and we can hope they have a least a Masters' degree to top off professional and other qualifications ("hope", unfortunately, is sometimes insufficient, this is not always the case). However, this higher degree will in all likelihood be in or on nursing and this cannot, I contend, meaningfully substitute for subject specific knowledge in the non-nursing disciplines from which the ideas educators deploy in teaching are plucked.

Perhaps then educators do not need to understand at first degree level the ideas or concepts they teach? Maybe sufficient relevant knowledge can be gained in other ways. A quick google search or something read at a time and place now forgotten could suffice? Perhaps if the introduced idea plays only a minor or subsidiary role in discussion it doesn't matter if educators do not understand what it is they are talking about? Or, at least, it doesn't matter until a student asks a question about it.

Alternatively, and I say this ironically, maybe nursing students do not need to understand the concepts they are introduced to in any substantive sense? Possibly, while nurse educators employ language and ideas taken from biology, ethics, pharmacology, philosophy, psychology, sociology,

*etcetera*, trivial or inconsequential understandings may be enough for our students? Maybe a smattering or "show" of knowledge is all that is needed? But that cannot be right.

Or, although nursing students work to obtain degrees, this qualification is awarded for doing and comprehending nursing – and nursing, as a discipline, is distinct from the disciplines it draws knowledge from. *Yes*. Nursing is not biology, ethics, pharmacology, philosophy, psychology, or sociology. Yet if a claim to distinctiveness supposedly signifies something of import, it does not. It's a red herring. It is not proposed that nursing is or resembles the disciplines it draws knowledge from. It is suggested that the drawing down and use of knowledge derived from non-nursing disciplines is problematic precisely because nurse educators are nurses and they are not biologists, ethicists, pharmacologists, philosophers, psychologists, sociologists, *etcetera*. Nurse educators lack the subject expertise that accompanies or facilitates membership of these disciplines. Nursing is a different discipline from those it takes knowledge from. That's the point. It is not an answer.

Of course, it might be objected that possessing a higher degree (or even just a degree) in the subject being taught and being an effective-competent teacher-communicator are not always synonymous. True. We have all met experts who could not convey their expertise. Yet is anyone seriously suggesting a lack of subject knowledge enhances teaching?

**Prescription**

That nursing students are primarily taught by nurses is entirely appropriate and utterly sensible. However, primarily need not mean always, and whenever it is prudent to introduce non-nursing expertise into the classroom, when this introduction enhances student learning, this should occur. University nursing schools and faculties may lack the financial means or ability to access suitably qualified non-nursing staff. However, I suspect few people disagree with the rightness of this suggestion.

More contentiously, beyond collaborative interdisciplinary co-working, perhaps nurse educators ought to be actively guided (overseen) by non-nursing subject experts when ideas taken from non-nursing specialities are taught? This might offend pride, and oversight would undoubtedly be cumbersome and ungainly to enact. Nonetheless, by analogy nurses would expect to be called upon to inform non-nurses if they spoke about nursing, and absent subject expertise, a willingness on our part to admit ignorance and seek help when alien concepts are recruited for and utilised in teaching could be a virtue.

Or maybe nurse educators simply need to admit the problem outlined here – and then – find ways of creating "cultures of teaching" in which the boundaries or edges of knowledge could be explored and where needed expanded? This is an attractive (cosy) idea. Yet given the hectic reality of university life, given incessant business, even talking matters through may prove difficult.

These remedies (if that is the right word) are not incommensurable. Two or more could be pursued simultaneously and others might be formulated. Clearly, however, a lot more work needs to be done before headway can be made regards the problem addressed here. Outside of nursing new developments in, for example, vice epistemology (Tanesini, 2021) might be recruited to suggest how this particular elephant in the room could be described, and more generally, Cassam (2014, 2007) or Markauskaite and Goodyear's (2017) work is potentially of relevance. That said, non-nursing scholars writing on and around the subject of this paper tend not to be referenced in our literature, and to emphasise the seriousness of the issue, to stimulate interest, to draw a response, a deliberately spikey approach to argumentation has been employed. The stridency of claims advanced may thus be overly brash. Forgive me. However, while a great deal of attention focuses on student evaluations of teaching (Padgett, 2021), educational skills development (see e.g., Cayir and Ulupinar, *in press*), and the complexity of health education (Pueyo-Garrigues *et al*, 2021), epistemic competence of the sort discussed in this paper is inadequately addressed by nurse educators – and here I include myself. Hopefully, it goes without saying that the faults I find in others must (a deliberately harsh word) also infuse my own teaching. And thus, while I arrogantly and somewhat primly point fingers, few are without sin here, me least of all. (Poignantly, at the time of writing, I find myself attached to a third-year undergraduate module on management-leadership, subjects I know next to nothing about.)

In conclusion, this is not an attack upon nurse education, professionalism, or professionalisation. Quite the reverse. I simply link improvement with problem identification-resolution, and here I highlight a problem. Naturally others will disagree. Some may argue that "nursing theory" needs to advance to a stage where external or non-nursing ideas are unnecessary. That is not my position. I do not think this plausible or desirable. Rather, ultimately, I suspect previously described differences regards alternative opinions on the telos-endpoint of teaching more readily capture contrasting vantages on this issue. Thus, if university nurse education is at root performative rather than critically oriented, if students simply require instruction in "correct" or "agreed" behaviours-opinions-values, then questions posed in this paper evaporate. Crudely, if students merely need to

learn to do and think as they are told, they do not also need to comprehend the rationale underpinning instruction in any deep or comprehensive way, and no one need worry about the epistemic competence of educators (as defined). Moreover, where education contributes to the production of a pliant and biddable workforce, meaningfully examining and unpacking why nurses do what they do might reveal or lead to ideational conflict/dispute and – some might argue – such outcomes are best avoided. This phrasing again overeggs to make a point. Nevertheless, I presume readers of this journal do not subscribe to reduced conceptions of education of the sort parodied here. I suspect almost all educators recognise some of what is discussed in this paper in their own teaching, and I am told (albeit *sotto voce*) that concerns regards educator ability to teach ideas derived from non-nursing disciplines in the absence of subject expertise are widely if not universally shared. Therefore, while the problems sketched are complex and troubling, and this is not a topic we like to think about, if your reaction to reading this is "how rude, therefore, he must be mistaken!", please, why am I mistaken? Is there really no issue? Really?

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