Transcript of talk given on 04.02.21. by Martin Lipscomb titled *Complexity and ambition in nurse education*.

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The presentation was made based on organising notes. This is a transcript of what was said.

Complexity and ambition in nurse education

In the time available to me I would like to talk about complexity, and a few of complexity's potential implications in university nurse education. My contribution is therefore, compared to those of my fellow panellists, a tad prosaic.

I start from the assumption that nursing and nurse education describes a complex undertaking. This simply states the obvious. However, I don't think educators always acknowledge complexity, and if they were encouraged to do so, my suspicion is that educators would, collectively, find themselves challenged in interesting ways. Ways that might and perhaps should prompt a more ambitious line to be pursued when interacting with students.

Of course, complexity is a woolly term, and complexity isn't simply complication. Nonetheless, the descriptor nicely, if imprecisely, captures problematic issues that overlap and interleave. To illustrate what I mean, I use an example.

At short notice, a colleague is asked to deliver a single standalone session to a reasonably large group of undergraduate students on the subject of health promotion. In her presentation only relative risk ratios will be discussed. Absolute risk will, categorically, not be mentioned. And just to be clear about the difference, if the absolute risk of developing a disease is 2 in

100, and some behaviour increases relative risk by 50% – that 50% relates to the 2 – so the absolute increase in risk is 50% of 2, which is 1.

What is my colleague doing? We can identify a range of factors, some probable, some potential, that together may be influencing her decision making. Each has philosophic implications, each feeds into the other.

First, my colleague may be restricting what she is talking about to meet professional expectations. That is, in the UK, health promotion tends almost always to rely on relative risk figures. However, should she not at least keep open the possibility of differentiating between her role as a nurse, a member of a profession, and her role as a university lecturer?

Personally, even if my profession adopts a particular approach to nurse-patient interactions, an approach reflecting wider policy decisions, as a lecturer, I don't consider myself duty bound to limit teaching to meet professional obligations. So, I would introduce students to relative and absolute risk ratios. I would invite them to consider using both ratios when discussing risk with patients.

In this particular instance I suspect no one will be particularly bothered about the profession-lecturer distinction being made, and my assumptions might of course be disputed. However, in an edited book coming out – hopefully – later this year, in my chapter, I explore tensions between how *as educators* and how *as nurses* we might engage differently with the idea that pain is what the patient says it is, and in that instance the distinction being drawn becomes much more visceral.[1]

Returning to the example in hand, second, my colleague is possibly avoiding absolute risk because she is concerned that students might become confused if they encounter too many statistics. A great deal of research concludes that many, not all, but many nurses find statistics and math difficult. If as an experienced educator my colleague anticipates student confusion

[1] *Complexity and Values in Nurse Education: Dialogues on Professional Education*. Editor M Lipscomb. Series: Routledge Research in Nursing and Midwifery – working title.

when statistics are discussed, if for that reason she avoids talking meaningfully about statistics, then we should acknowledge a serious problem. A problem of ability.

Statistically illiterate or statistically challenged students will not only face problems engaging with the reasoning underpinning health promotion, presumably they also confront hurdles when it comes to evidence-based practice more generally. These students are unlikely to be able to make much sense of, for example, quantitative research. And, thus, we here confront an epistemological issue with practice implications. As an aside, within the UK, during recruitment we take into account the values that potential recruits say they hold. However, recruiters pay scant attention to measurable or proven statistical acumen. So, these problems are hardly unfathomable.

Third, the story speaks to professional values. Nurse leaders advance an enormous number of claims regards the values that, allegedly, nurses hold or should hold. I think many of these claims lack credibility, albeit that the values propounded are ones I accept. Nonetheless, many nurses assert that they value and seek to promote patient autonomy, and with this in mind, why is my colleague emphasising relative risk ratios – which can sound scary – in preference to absolute risk, which may be less intimidating? Could it be that patients who are provided with relative and absolute risk ratios might not behave in ways deemed appropriate?

Arguably, nurses who only talk about relative risk might act, or appear to act, manipulatively and paternally. They potentially deny patient autonomy by undercutting the ability of patients to make fully informed decisions. Paternalism can be defended. Yet the arguments involved in this defence trample over a value – autonomy – many nurses say they prioritise. And so, potentially, the example throws into relief complex tensions between what we say we value and, possibly, how we act.

Following on from this, fourth, the story could make us think about the meaning of health and the relation of health to a life well lived. A good life isn't one that minimises risk taking in all and every situation. And health is not – and nor should it be – always and necessarily the only thing people value and seek to maximise. Health professionals can't presume they know best.

And, if nothing else, crude versions of health promotion ignore the self-evident truth that individuals take different positions on the risks they are prepared and indeed want to accept.

Fifth, in her lecture, my colleague will have brought together ideas taken from multiple fields of inquiry. Thus, nursing claims – sensibly and legitimately – to have an interest in knowledge derived or taken from an array of activities and disciplines. For example, in addition to what might be termed practical or situated understandings, nurses engage with and require proficiency in knowledge derived from the physical and biological sciences, the social and psychological sciences and, also, the moral and human sciences.

Knowledge derived from all of these sciences plays a part in health promotion, and in this confabulation connections between distinct fields of knowledge are made. However, problematically, longstanding and nuanced arguments surround – and here I simplify for the sake of argument – relations between the physical or experimental sciences and the human and moral sciences. These debates explore ideas about what counts as knowledge and truth, as well as the ends or purposes to which knowledge or truth can be put, and hence, in a discipline such as nursing, a discipline that aspires to bring these knowledge forms together *and* instrumentally or purposefully to apply them, nurse educators ought, maybe, to have a view on discussions about, for example, the unitary or non-unitary nature of science. As well as whether or to what extent logical connections might or might not be sustainable between these fields or forms of understanding.

Having a view here might be important. The position we take on such matters – and ignoring them is a position – presumably influences how we teach and, also, how we conceptualise links between taught content and clinical practice.

The theory-practice divide articulates, in part at least, the difficulty of connecting knowledge derived from universalising theory with the messiness of context laden reality. Linked to this, we might also think about differences in causal claims that are permitted within and between the various branches of knowledge and understanding. So generalised causal claims such as "smoking causes cancer" and singular causal claims regards, for example, an instance of smoking, or an individual's smoking, are difficult, they may be impossible, to square.

Yet in a practice-based discipline such as nursing, educators like my colleague link theory with practice and, as part of this linkage, just as she will implicitly if not explicitly have a view on science's unitary or non-unitary nature, she will in all probability have laced together general and specific causal explanation but, possibly, she might not have considered whether these linkages are defendable.

This one example story throws out lots of things to think about, and insofar as the topics raised interconnect or interleave, and are problems, I consider them complex problems. In my view, nurse educators don't adequately engage with complex issues of the sort described. Instead, we gloss complexity. I also suppose this lack of engagement leads educators to be less ambitious in their interactions with students than they might otherwise be. For example, failing to introduce students at an appropriate level to questions around the unitary or non-unitary nature of science and/or difficulties in connecting general with specific causal claims – at an appropriate level – means students cannot even begin to think about such issues.

However, I'm not criticising individuals. University-based educators do their best to produce accredited learners, and the work this generates, and all the associated admin and paperwork and fuss dominates everyday activity. Further, insofar as course requirements are set and steered by external bodies, when it comes to determining what is taught and how teaching occurs, educator hands are often metaphorically tied.

Further, within the academy, relative under-resourcing, bloated curriculums, time scarcity, a diverse student body, variable educator ability, and the legitimate requirement that subjects be abridged to aid digestion all contribute to the flight from complexity. Here, however, in the remaining seconds, I'd just like to mention one important element in this flight, that is, nurse educator's lack of subject expertise.

University nurse educators tend, sensibly, to be nurses. However, removed from practice, clinical or field specific knowledge quickly ossifies. And when nurse educators introduce students to ideas derived from the disciplines of biology, pharmacology, sociology, psychology, ethics *etcetera* – that is, knowledge derived from the sciences and forms of

understanding referred to earlier, subjects with extensive hinterlands of dynamic evolving understanding, then because they are primarily nurses, educators will not also be subject experts if by expertise we (somewhat tautologically) mean someone who has a higher-degree, or even just a degree, in the non-nursing subjects being taught.

Beyond early year introductions, and certainly when we're talking about post graduate study, this lack of subject expertise presumably matters. Generalists cannot do everything equally well. This isn't an attack upon professionalisation or professionalism, it's just a truism.

In conclusion – the woolly concept of complexity might give coherence to some if not all of the difficulties university nurse educators confront. And, while a great deal of excellent educative practice takes place, to restate, failure to engage with complex issues means educators are not, perhaps, as ambitious and effective as they possibly could be. Thinking about these issues raises problems with philosophic content. These things are worth considering.

M Lipscomb – 04.02.21.