

FACULTY PRACTICE COMPETENCIES: NURSE EDUCATORS' PERCEPTIONS

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In recent years the importance of practice as an integral part of the faculty role has been receiving greater attention. Traditionally, nursing faculty teach students in classroom and or clinical settings but do not engage in clinical practice themselves. Just as Nichols (1985) has stated, "When we teach but do not touch, we lose our specialized competence" (p. 85), many faculty members feel that they must remain clinically competent because they cannot teach what they no longer practise. This has prompted many university nursing programs to place practice as one component of the faculty role along with teaching, research and service. Faculty practice is not universal. In some institutions it is mandatory, while in others it is optional. Community colleges in Ontario have no system of faculty practice in place.

It is generally assumed that those who teach in clinical settings are clinically competent. Yet what constitutes faculty practice competencies is not noted in the literature. In one study (Yonge, 1986), it was found that faculty members did not view clinical competence as a simple and concrete behaviour. Instead they associated it with "evaluation, delivery style, prioritizing of content, climate, selection of materials, assignments and relationships with students and nursing staff" (p.23). This survey grew out of the need to identify specific clinical competencies required by nurse faculty members in order to meet their multiple role demands. Nursing faculty at universities and community colleges in Ontario were asked to rate and rank the practice competencies for a beginning nurse educator and give their opinions regarding this aspect of their roles.

Faculty practice - defined

There still exists a great deal of confusion and disagreement about faculty practice and faculty practice roles (Acorn, 1987). Faculty practice is often confused with faculty supervision of students during their clinical placement. According to Christman (Machan, 1980) however, faculty practice goes beyond the clinical teaching role. He defines it as involving a practitioner-teacher who delivers health care to clients by her- or himself while undertak-

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ing primary nursing in a hospital unit. Each practitioner-teacher teaches using her or his own set of patients, sharing them with the students while teaching. Faculty practice goes beyond the mere acquisition and maintenance of clinical skills.

Faculty practice need not be confined to a hospital setting. The same concept can be utilized in a community setting (Machan & Roberts, 1980) or in a variety of clinical practice arrangements (Collison & Parson, 1980).

Importance of faculty practice

The advantages of integrating education and practice have been widely noted in the nursing literature. Although faculty practice is not new, because of the increasing chasm between education and service, there is a general acknowledgment that the profession and discipline must integrate. According to Mauksch: "How did it come about that so many faculty members who teach a 'practice' [nursing] are not engaged in it themselves? Professionals in other fields such as medicine, dentistry, architecture, and the ministry teach through their practice." (1980, p. 20).

Algate warns that there are, "dangers inherent in the continued separation of discipline and profession...a profession without connections to its discipline turns elsewhere for answers to its problems...stunting its autonomy...subjugates us to the powers of others...for the health and survival of nursing, it is necessary for nurse faculty to take hold of the practice arena." (1986, p. 75).

She believes that the academicians should form the critical connection between theory, research and practice otherwise they risk getting out of touch and becoming irrelevant. Faculty members who are engaged in practice teach from their current clinical experience rather than from textbooks and periodical articles (Wakefield-Fisher, 1983), thus enhancing the quality of their teaching. A non-practising faculty member has a negative impact on the education of student nurses. Mauksch (1980) says that, "increasingly the students ask whether their teachers are capable of nursing practice" (p. 21). Holzmer (1984) claims that the outcome of faculty practice is that students are better prepared to face the real world of nursing.

There are several other advantages to faculty practice; the following are the main ones:

1. Currently, most nursing programs are conceptually based. At first, this provides theoretical images of nursing for student nurses that can be translated into practice. Secondly, academic and clinical teaching both proceed from a conceptual framework(s) (Neely, et al., 1986). This has the additional

advantage of allowing faculty members to refine conceptual frameworks through research as well as helping in the advancement of nursing science.

2. Role modelling for students is an important faculty role that is improved by faculty practice. Students should model their own practice by watching and working with faculty members in action (Archer & Fleshman, 1981). If faculty members do not practise, the students are forced to seek their role models from among hospital staff - a problem often voiced by many faculty members, who lament the poor quality of nursing care in some settings where students are having clinical experience and the failure of nursing staff to implement research findings. (Mauksch, 1980; Schlotfeldt & MacPhail, 1969).

3. Faculty practice obliges faculty members to become familiar with hospital settings and personnel and thereby help in creating an environment conducive to learning. Instead of being viewed as guests or intruders, they come to be viewed as master practitioners (Basteyns, 1980; Roncoli, 1985). Their advanced education enables them to act as a resource to staff nurses, and thus help their professional growth. This, in turn, improves staff-teacher relations.

4. Faculty practice increases the faculty members' acceptability among other health professionals who often question their right to decision making in an arena where they do not participate in the delivery of the very services they proclaim to promote (Mauksch, 1980). In one of their studies, Chute and Oechsle (1986) discovered that, while faculty members perceived themselves to be competent both as teachers and as practitioners, hospital RNs indicated a relatively low level of confidence in the competence of faculty members for either role. Therefore, it may be said that faculty practice improves members' credibility among professional colleagues.

5. Faculty practice is reported to result in improvement in the quality of nursing care (Basteyns, 1980; Schlotfeldt & MacPhail, 1969). Pierik (1973) reported, from her own experience, that patients said they received better quality care as a result of her joint roles in teaching and practice.

Barriers to faculty practice

In spite of the reported benefits, faculty practice is not free from problems. Role overload, (that is, excessive demands and lack of time to meet expectations adequately), is of real concern to faculty members who practice. The inability to meet the demands of an academic position and the obligations of a practitioner (Duffy & Halloran, 1986; Wakefield-Fisher, 1983), as well as the inability to engage in sufficient research or professional writing are some of the frustrations experienced by faculty members who are engaged in clinical practice (Lambert & Lambert, 1988).

Faculty members who practise interface with two value systems - academia and practice. Having to deal with two normative worlds, each with different goals, standards, protocol and expected behaviour, leads to role strain (Batey, 1969; Sweeney & Ostmol, 1980). The adoption of a second profession (education), while maintaining the first (nursing), demands contradictory responses, actions and thought. One of the criticisms of faculty practice is that the patients, rather than the students, become the focus (Smoyak, 1978). Having to decide between the needs of patients and those of students produces role conflict and role strain (Kuhn, 1982). It was reported in one study that faculty members who tend to be more student-oriented than patient-oriented experience increased role strain (O'Shea, 1981).

Lack of recognition and limited rewards for practice deter many from engaging in clinical practice. Many researchers recognize that practice is considered less important than teaching and research, and that it is not highly valued when the issue of promotion and tenure is considered (Radcliff & Andresky, 1988; Yonge, 1985).

Some models of practice

Several avenues by which faculty practice may be encouraged are described in the literature. A collaborative agreement between a service and an educational institution for a joint appointment is the most common (Schlotfeldt & MacPhail, 1969; Collison & Parsons, 1980; Christman, 1980; Roncoli, 1985; Cook & Finelli, 1988).

Independent practice, whereby nurse educators develop their own practice setting to provide service to clients and to allow students to provide care under her or his guidance has also been suggested (Millonig, 1986).

Employment of faculty members during the summer months or other free time has also been tried (McGriff, 1985; Smith & Basch, 1984). However, taking an occasional, part-time clinical position is not seen as true faculty practice by purists (Wakefield-Fisher, 1983; Algase, 1986).

Background of the Study

The literature on faculty practice deals primarily with university nursing faculty; issues in relation to faculty teaching in other than a university setting are not specifically addressed. For faculty practice to be an integral part of nursing education, it should be equally applicable to all faculty members who are engaged in the preparation of future registered nurses. Therefore, faculty members, regardless of the type of institution, should engage in practice, and do so with competence.

Competencies for beginning level practitioners and for many masters level clinical nurse specialists are well-established. In contrast, practice competencies for nurse educators are not spelled out in the literature. However the literature suggests that nurse educators practice occurs at an advanced level (Algase, 1986), possibly because of an education that includes graduate work and clinical specialization (Cook & Finelli, 1988). A clinical specialist may or may not engage in teaching and research. A faculty member who teaches and, depending on the institutional mandate, conducts research and engages in scholarly activities, may also practice. Hence the faculty role is seen as the synthesis of education, practice and research (Neely et al., 1986).

The purpose of this study was to establish competencies that are essential for a faculty member to adopt a practice role. As well, nursing faculty in universities and colleges were surveyed to determine if they differ in rating these competencies.

Theoretical framework

According to role theory, roles are learned through a process of symbolic interaction by which a person acquires the required knowledge, skills and dispositions, and responds accordingly (Hardy & Conway, 1978). "Learning from observing a model...is one of the most efficient and pervasive methods" (Sarbin & Allen, 1968, p. 548). Student learning takes place by observing and internalizing the practice of their teachers - a practitioner role that they are encouraged to emulate. Therefore, role theory was used to identify competencies necessary for the practice role. These competencies are listed in Table 1.

Method

Design

This study grew out of a larger one which developed a questionnaire from a conceptual model of multiple roles of nurse faculty (Choudhry, 1992). The 15 competencies listed under each subgroup were either explicit or implicit in the literature. They establish that the practitioner is an expert care provider, has interpersonal competence, is an agent of change, is a researcher and an educator. This ensured content validity of the questionnaire. The questionnaire was pilot-tested on a sample drawn from universities and colleges (N=20) for clarity, redundancy, comprehension, ease and accuracy. Based on the comments received the questionnaire was refined and validated for its internal consistency (Cronback's alpha >.88).

Competencies were rated on a Lykert-type scale (1 being least desirable and 5 being most). The respondents were asked to rate each of 15 com-

petencies that they considered a nurse educator should have "ideally" and which, in their view, a "beginning" educator needs. The "ideal" level rating provided a point of reference for rating "beginning" level competencies. The questionnaire also included a series of opinion questions dealing with the importance of the practice role, nurse educators' credibility as it relates to clinical competence, need for faculty members to act as role models and how clinical competency is maintained.

Sample

All full-time faculty members teaching in eight university nursing programs, and 50% of all faculty members teaching in twenty-three community college nursing programs in Ontario were sampled. The questionnaires were mailed, along with a stamped self-addressed envelope. Although the anonymity of responses was assured, it was important to compare them - therefore, the questionnaires were colour-coded. Out of a total of 626 questionnaires, 291 (46.7%) were returned. Not all respondents answered all the questions, therefore only 250 (191 college faculty and 59 university faculty) were used in the final data analysis.

Analysis of Data

Multivariate repeated measures of analysis of variance was used to test for any difference between university and college respondents. The repeated factor compared levels ("beginning" and "ideal"). Wilks' multivariate F-test was then used to test the significant difference between the groups. Where a significant MANOVA F was obtained, analysis of variance (univariate F) on each dependent variable was examined to determine which of these variables were statistically significant and contributed to the overall significant multivariate F. Chi-square analysis was used to compare the opinions of the two groups. The alpha level was set at .05.

Findings

The ranking of all 15 competencies was the same for both university and college faculty members (Kendall's Coefficient of Concordance, $W=.94$, $p<.002$). Competencies in Table 1 are listed according to the final ranking. All "ideal" level competencies were rated greater than 4, indicating their overall importance for faculty practice.

As can be seen from Table 1, ten of the 15 "beginning" level competencies received a mean rating of 3.1 to 3.8, placing them above the middle of the desirability scale for a beginning faculty member. This demonstrates that faculty members provide expert care with a theoretical and conceptual base, and use research findings in their practices. They also act as educators, preceptors and mentors, and are agents for change.

Table 1***Rating and Ranking of Practice Competencies by University and Community College Faculty, N = 250***

Rank	Competencies	Means	SD
1.	Identifies and uses, (thus providing a demonstration of) a conceptual framework for nursing practice.	3.52	1.05
2.	Identifies agencies' philosophy and assesses whether it is congruent with own philosophy of nursing.	3.59	1.04
3.	Designs educational programs for clients/health worker by working with other members of health team.	3.20	1.01
4.	Supports human dignity while engaging in professional practice.	4.78	.52
5.	Prescribes, decides, influences and facilitates change in nursing and health care by selecting appropriate strategies.	3.43	1.09
6.	Functions as a preceptor/mentor/guide to students and other nurses.	3.64	1.10
7.	Demonstrates effective interpersonal skills.	4.58	.64
8.	Participates in the improvement of nursing care through generating and advancing nursing theories.	2.97	1.07
9.	Demonstrates an expertise in a specialized area of clinical nursing.	3.46	1.12
10.	Uses research findings in the practice of nursing to improve client health.	3.44	1.03
11.	Interprets the roles and functions of nurses to others.	3.81	1.03
12.	Collaborates with others within the agency/community for the purpose of improving health care.	3.89	.99
13.	Provides theory-based nursing practice.	3.92	.99
14.	Acts as a client's advocate.	4.27	.93
15.	Demonstrates an understanding of values and beliefs of others.	4.50	.78

The competency that requires faculty members to participate in the improvement of nursing care through generating and advancing nursing theories received the lowest rating (2.8). The remaining four were rated between 4.0 and 4.8 - relatively high on the desirability scale, indicating that competencies for interpersonal skills were rated highest by both sets of faculty (see figure 1). However rating was significantly different between university and college faculty members: $F(15,234)= 2.74, p<.001$. The univariate F's revealed that the significant difference arose specifically from the ratings in the competencies numbered 9, 10, 13 and 14 (see Table 2).

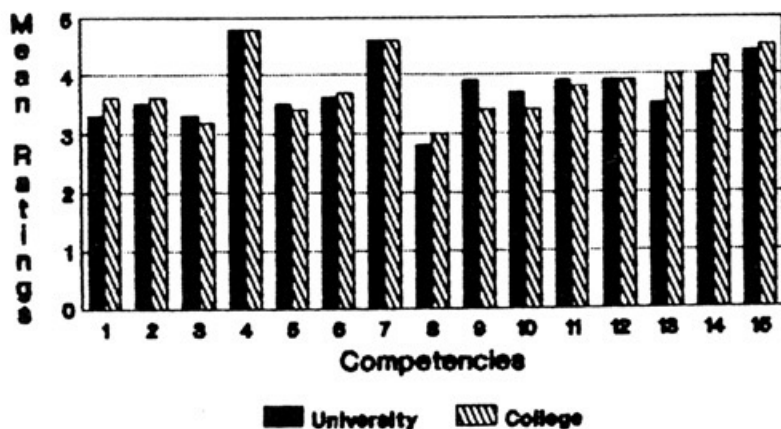


Figure 1
Beginning Faculty and Practice Competencies
as Rated by University and College Faculty

Competency #9: The competency to demonstrate an expertise in a specialized area of clinical nursing was rated higher by university faculty members (3.9 for beginning and 4.5 for ideal) than by community college faculty members (3.4 for beginning and 4.0 for ideal). $F(1,248)=9.78, p<.002$.

Competency #10: The competency to use research findings in the practice of nursing to improve client health was also rated higher by university faculty members (3.7 for beginning and 4.6 for ideal) than college respondents (3.6 for beginning and 4.2 for ideal). $F(1,248)=8.24, p<.004$.

Competency #13: The competency to provide theory-based nursing practice received a higher rating by college respondents (4.1 for beginning and 4.6 for ideal) than from university faculty members (3.5 for beginning and 4.4 for ideal). $F(1,248)=9.60, p<.002$.

Competency #14: The competency to act as a client's advocate was also rated higher by community college respondents (4.3 for beginning and 4.7 for ideal) than by university faculty respondents (4.0 for beginning and 4.6 for ideal). $F(1,248)=6.32, p<.01$.

Table 2

Univariate/Multivariate Analysis of Variance by Institution Type for Faculty practice Competencies

Variables Faculty Faculty	University		Comm.Col.		MANOVA			ANOVA		
	M	SD	N	M	SD	N	Wilks	F	df	p
							.85032		5.234	
COMP. #9 'b'	3.9	.84	59	3.4	1.17	191		9.78	1,248	.002
'i'	4.5	.77	59	4.0	1.08	191				
COMP. #10 'b'	3.7	.98	59	3.6	1.04	191		8.24	1,248	.004
'i'	4.6	.56	59	4.2	.83	191				
COMP. #13 'b'	3.5	1.07	59	4.1	.93	191		9.60	1,248	.002
'i'	4.6	.87	59	4.6	.61	191				
COMP. #14 'b'	4.0	1.12	59	4.3	.85	191		6.32	1,248	.01
'i'	4.6	.97	59	4.7	.69	191				

* This F indicates the result of all 15 variables; only 4 univariate significant variables are included in this table.

It is important to note that there was no statistically-significant difference in the ratings of the 11 remaining competencies. Analysis of the difference between the beginning and ideal measures on the repeated factor was significant for each variable: $F(15,234)=35.28$, $p<.000$. The difference between the "beginning" and the "ideal" was the same for university and college faculty.

Discussion

The results of the study indicate that both university and community college faculty considered all practice competencies to be desirable. Thus, there is a clear expectation that a "beginning" faculty member should have competencies that are at an advanced level. This suggests that some prior preparation, at least at the masters level, is needed for all new nurse educators.

Specialized clinical preparation at the masters level and research preparation preferably at the doctoral level are the norm in universities. As such, a higher rating by university faculty members for competency demonstrating an expertise in a specialized area of clinical nursing and using research findings in practice is not surprising. Advanced clinical preparation is not a requirement for college faculty. As such, despite the value they might place on these two competencies, their low rating is an indication of their own role-deficit. Also, because college faculty members are usually expected to teach in more than one clinical area, specialization in one area is problematic. However, if practice becomes a role expectation for college faculty members in response to a mandate from the profession, then it may be desirable that masters level preparation becomes a requirement for all beginning college faculty members. Those already teaching in colleges may, instead, be encouraged to receive extended clinical practice in a specific area.

In comparison, college faculty members gave a higher rating for competency in providing theory-based nursing practice and acting as client advocates. Nursing theories have been incorporated recently in the nursing programs of most community colleges. Their higher rating might indicate a heightened commitment to this aspect of the professional mandate.

The outcome of this study attests to the importance of faculty practice. Although there was a significant difference ($X^2=3.8$, $p<.04$), the respondents were of the opinion that teaching in nursing requires competence in practice as well as competence in teaching (86% university and 94% college responses). Respondents also felt that although they could improve clinical skills (85% of university and 88% college), they could not maintain clinical competence only through supervision of their students (62%). This view is

supported in the literature: "The more the teacher is away from the bedside, the greater the possibility that she will not gain knowledge of the patients required for teaching the kind of nursing she espouses" (Christy, 1980, p.497).

In spite of this, while 77 percent of university faculty members were teaching in the clinical area, only 59 percent were engaged in some form of clinical practice, regular or periodic. A larger percentage (88%) of community college faculty members were teaching in the clinical area, but a comparatively smaller number of them (51%) were practising regularly or periodically. A higher percentage of practice among university faculty members may possibly be attributed to joint clinical and academic appointments that are the norm in some university programs. As mentioned earlier, there is no such arrangement in the college system.

As documented in the literature, when faculty members teach through their practice, they facilitate the transition from the classroom to the clinical area. By being a role model, a faculty member shows students how to make critical clinical judgements, solve problems and demonstrate effective interpersonal skills. This aspect of the practice role was considered important by both groups of faculty (87% university and 90% college).

If practice is to become a viable part of the faculty role, the consensus in this study about the importance of practice could prove to be a unifying force. It should also have a compelling influence on educational and employing institutions to make faculty practice the norm.

REFERENCES

- Acorn, S. (1987). *Joint academic/clinical appointments: a Canadian perspective*. Alberta Association of Registered Nurses, Edmonton, Alberta.
- Algate, D.L. (1986). Faculty practice: a means to advance the discipline of nursing. *Journal of Nursing Education*, 25(2), 74-76.
- Archer, S.E. & Fleshman, R.P. (1981). Faculty role modelling. *Nursing Outlook*, 29(10), 586-589.
- Batey, M.V. (1969). The two normative worlds of the university nursing faculty. *Nursing Forum*, VIII(1), 5-16.
- Basteyns, M. (1980). Developing the practice/teacher role in private hospital setting. In L. Machan (Ed). (1980) *The Practitioner-Teacher Role: Practice What You Teach*. Wakefield, Mass.: Nursing Resources.
- Choudhry, U. (1992). New Nurse Faculty: Core Competencies for Role Development. *Journal of Nursing Education*, 31(6), 265-272.
- Christy, T.E. (1980). Clinical practice as a function of nursing education: An historical analysis. *Nursing Outlook*, 28(8)493-497.
- Christman, L. (1980). The practitioner teacher: a working paper for the faculty at Rush University College of Nursing and Allied Health Sciences. In L. Machan (Ed). (1980) *The Practitioner-Teacher Role: Practice What You Teach*. Wakefield, Mass.: Nursing Resources.

- Chute, G.E. & Oechsle, L.H. (1986). Split images: compared perceptions of nursing faculty. *Journal of Nursing Education*, 25(4), 163-165.
- Collison C.R. & Parson, M.A. (1980, Nov). Is practice a viable faculty role? *Nursing Outlook*, 28, 677-679.
- Cook, S.S. & Finelli, L. (1988). Faculty practice: A new perspective on academic competence. *Journal of Professional Nursing*, pp. 23-29.
- Duffy D.M. & Hollaran, M.C.S. (1986). Meeting the challenge of multiple academic roles through a nursing centre practice model. *Journal of Nursing Education*, 25(2), 55-58.
- Hardy, M.E. & Conway, M.E. (1978). *Role Theory: Perspectives for Health Professional*. Norwalk, Connecticut: Appleton-Century-Crofts.
- Holzmer (1984). Positioning to confront a changing community: repatterning of nursing care delivery and education. *Nursing and Health Care*, 5(9), 487-490.
- Kuhn, J.K. (1982). An experience with a joint appointment. *American Journal of Nursing*, 82(10), 1570-1571.
- Lambert, C.E. & Lambert, V.A. (1988). A review and synthesis of the research in role conflict and its impact on nurses involved in faculty practice. *Journal of Nursing Education*, 27(2), 54-60.
- Machan, L. (Ed). (1980) *The Practitioner-Teacher Role: Practice What You Teach*. Wakefield, Mass.: Nursing Resources.
- Machan, L. & Roberts B. (1980). Health clinic for the elderly: Practitioner/teacher in a community setting. In L. Machan (Ed). (1980) *The Practitioner-Teacher Role: Practice What You Teach*. Wakefield, Mass.: Nursing Resources.
- Mauksch, I.G. (1980). Faculty practice: a professional imperative. *Journal of Nursing Education*, 19(3), 21-24.
- McGriff, E.P. (1985). Fulfilling the commitment for practice without joint faculty appointments. *Perspectives in Nursing 1985-1987*, New York: National League for Nursing, 92-98.
- Millonig, V.L. (1986). Faculty practice: A view of its development, current benefits and barriers. *Journal of Professional Nursing*, 1(2), 166-172.
- Neely, C.A., Truby, S.R., Shaughnessy, J.A., Baker, E.R., Burkhardt, M.A., Nagai-Jacobson, M.G., Snodgrass, F.G. & Youngblood, J. (1986). Professional role synthesis for nursing faculty: A redefining of faculty practice. *Journal of Nursing Education*, 25(8), 345-348.
- Nichols, C. (1985). Faculty practice: something for everyone. *Nursing Outlook*, 85-90.
- O'Shea, H.S. (1981). Role orientation and role strain of clinical nurse faculty in baccalaureate programs. *Nursing Research*, 31(5), 306-310.
- Pierik, M.M. (1973). Joint appointments: collaboration for better patient care. *Nursing Outlook*, 21(9), 576-579.
- Radcliff, L.P. & Andresky, J.T. (1988). Traditional academic requirements: Faculty perceptions. *Journal of Nursing Education*, 13(3), 9-13.
- Roncoli, M. (1985). Faculty practice: making it work. *Perspectives in Nursing - 1985-1987*. New York: National League for Nursing.
- Sarbin, T. & Allen, V. (1968). Role Theory. In G. Lindzey, & E. Aronson (Eds.), *The Handbook of Social Psychology*. Reading, Mass.: Addison-Wesley Publishing Company.
- Schlotfeldt, R. & MacPhail, J. (1969). An experiment in nursing - a rational and characteristics. *American Journal of Nursing*, 69(5), 1018-1023.
- Smith, C. & Basch, L. (1984). Clinical education for nurse educators and administrators. *Nurse Educator*, 9(4), 11-14.
- Smoyak, S.A. (1978). Teaching as coaching. *Nursing Outlook*, 361-363.
- Sweeney, S.S. & Ostmo, P. (1980). Academic freedom: A relevant concept for collegiate nursing education. *Nursing Forum*, XIX(1), 4-8.
- Wakefield-Fisher, M. (1983). Faculty practice. *Journal of Nursing Education*, 22(5), 207-210.
- Yonge, Olive (1985). *Nurse educators' perception of clinical competence*. (A research project funded by the Alberta Association of Registered Nurses), Edmonton, Alberta.
- Yonge, Olive (1986, January). *Nurse educators' perception of clinical competence*. AARN News Letter, 42(1), 23-5 Edmonton, Alberta.

RÉSUMÉ

Compétences des professeurs dans l'exercice de la profession infirmière : perception des enseignants

On a demandé aux professeurs de sciences infirmières des universités et collèges universitaires d'Ontario d'évaluer les compétences professionnelles des enseignants et de donner leur opinion sur cet élément du rôle du professeur. Les deux groupes ont indiqué que toutes les compétences énumérées étaient importantes. Toutefois, une différence importante est apparue dans quatre des quinze aptitudes. Tandis que les professeurs d'université ont accordé davantage d'importance à l'expertise dans un domaine spécialisé des sciences infirmières et à l'application des observations de recherche à l'exercice de la profession, les professeurs de collège considéraient comme plus importante l'aptitude à dispenser des soins infirmiers fondés sur la théorie et à défendre la cause des clients. Les deux groupes ont indiqué qu'ils croyaient que l'enseignement des sciences infirmières nécessitait aussi bien des compétences professionnelles que pédagogiques. À leur avis, les professeurs de sciences infirmières tout comme les autres professeurs qui exercent une autre profession doivent se consacrer à des activités professionnelles en plus de leurs activités d'enseignement et de recherche.