

FACULTY PRACTICE IN AUSTRALIAN NURSE EDUCATION: STATUS AND PROSPECTS

**REPORT PREPARED FOR THE
COUNCIL OF DEANS OF NURSING AND MIDWIFERY
(AUSTRALIA & NEW ZEALAND)**

by

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15th November 2005

Referencing this document

Holmes CA (2005) *Faculty Practice in Australian Nurse Education: A Report Prepared for the Council of Deans of Nursing and Midwifery (Australia & New Zealand)*. Canberra: Council of Deans of Nursing and Midwifery (Australia & New Zealand).

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Executive Summary

1. The language used in relation to faculty practice is sometimes confusing, and any assessment of the literature must establish in what sense terms are being used.
2. 'Faculty practice' in the United States, usually refers to a health service provided, and sometimes owned, by the academic institution. There are few such services in Australia.
3. In Australia, 'faculty practice' usually refers to clinical practice undertaken by a member of the academic staff of the university. There is significant overlap with the American concept, however, since a faculty health service is the primary location for such practice.
4. Faculty practice has all but disappeared in Australia, and this is widely attributed to cost implications, insurance problems and the burden of on-site academic workloads.
5. There is substantial evidence that faculty health services represent an important public expression of the clinical expertise and status of academic nursing staff, and that they may become centres of excellence, and thereby significantly contribute to attracting and retaining students.
6. Faculty health services provide closely monitored and expertly facilitated clinical placements for students.
7. Faculty health services may make a significant contribution to the well-being of underserved populations in the community.
8. Faculty health services, and faculty practice by academic staff, require agreements to be established in relation to contractual, financial and insurance arrangements, roles and objectives, and relevance to institutional aims and personal development.
9. The creation of faculty health services requires substantial investment of time, energy and funds, involving a variety of stakeholders.
10. Faculty health services should be the epitome of good practice and mechanism should be in place for evaluating clinical and academic outcomes.
11. Joint appointments and innovative 'hybrid' appointments are significant expressions of collaboration between the academy and health services, and are common in Australia.
12. Joint appointments in Australia commonly extend to professorial level and are usually associated with a specific nursing specialty or designated client group.

13. Joint appointees are especially susceptible to role ambiguities, work overload and loss of career direction. The dual role is reported to contribute little to either academic or clinical career prospects. Clear, mutually agreed responsibilities and goals are therefore essential.
14. Joint appointees, and academics engaged in faculty practice, may undertake very little, if any, 'hands-on' clinical work, with the focus tending to be on the support of students and the creation of a quality learning environment.
15. There is little empirical evidence regarding the value and drawbacks of joint appointments, including clinical appointments at professorial level, and most published accounts relate personal impressions.
16. Faculty practice may have largely disappeared in Australia because of the increased financial strictures placed upon universities since its introduction in the late 1980s, and the need for staff to focus on essential on-site academic activities.
17. Faculty practice is difficult to incorporate into traditional notions of scholarship, and thereby to contribute to the scholarly output of the institution or the academic profile of the individual.
18. The notion of 'clinical credibility' is complex and may not be appropriate to the role of academic staff as perceived by clinicians. Academic staff and clinicians tend to regard regular contact with the practice world as more important for academic staff than 'hands-on' clinical practice.
19. Where faculty practice is adopted, it should be the subject of formal agreements between all stakeholders, and issues relating to costs and legal liabilities must be resolved in advance.
20. Where faculty practice is adopted, there should be unambiguous aims and projected outcomes and it should be factored into staff workloads; there should be formal mechanisms for ensuring safe and competent practice; and, it should be incorporated into personal performance review procedures approved by the university.
21. The evidence supporting the traditional arguments in favour of faculty practice, such as bridging the gap between theory and practice, keeping academics up to date, and providing opportunities for clinical research, remains extremely weak.

1. Background, Aims and Introduction

This report accompanies a position statement on ‘faculty practice’ commissioned in August 2005 by the Australian Council of Deans of Nursing and Midwifery. It provides a systematic and critical review of the literature relating to faculty practice, supplemented by information obtained from Australian universities that have adopted or considered faculty practice schemes.

The material is arranged in five sections. Section 2 clarifies the confusing terminology that surrounds this topic, and defines some basic concepts.

The ‘core’ of the report is located in Sections 3, 4 and 5. Each addresses a different strategy by which academic nursing staff may engage with clinical practice: participation in the provision of faculty health services, making regular clinical practice an integral part of the academic role, and by taking up joint appointments or other hybrid roles. Each section begins with the background, describes the current status of the strategy outside Australia, then inside Australia, followed by a review of the benefits and advantages, and disadvantages and problems.

2. Definition of Terms

2.1 Nations Separated by a Common Language

Much of the literature on faculty practice originates in the United States. Before discussing specific definitions relevant to this review, it is therefore important to recall that certain key words have different meanings in American and Australian contexts, and that they are not used consistently within either context.

Crucially:

1. in Australia, *faculty* refers to an organisational unit within a university; in the United States, it refers to the academic staff who work in the university;
2. the word *practice* may refer to an activity (as in ‘many nurses engage in clinical practice’), but it may also refer to an organisational unit, or service, contributing to health care (as in ‘many nurses work in a clinical practice’); it might also be worth recalling that in Australia, according to the *Macquarie Dictionary*, the noun ‘practice’ and its verb ‘practise’ refer not only to any form of professional activity, but also to repeated activity with a view to improving performance; and,

3. *faculty practice* could therefore mean:

- a health service provided by university schools or departments;
- clinical practice engaged in by members of the academic staff; or,
- performance of clinical actions, by university staff, in order to maintain or improve their skills.

For no apparent reason, the first of these meanings is associated with the American concept of faculty practice, and the second and third with the British and Australian concepts.

Because of these nuances, an inelegant level of repetition is sometimes necessary to avoid misunderstanding. In this report the abbreviation ‘FP’ will be used to refer to ‘faculty practice’, and it should be clear in each case which type of faculty practice is intended. Where confusion may arise, the term ‘faculty health service’ has been employed to represent the American concept, as described below.

2.2 Faculty Practice as Faculty Health Services

FP has its origins in American university nursing departments and, in this context, has been defined simply as the employment of nursing faculty in health care settings outside the educational institution (Langan 2003, p.77). More broadly, it refers to the provision of a clinical health service under the auspices of the university, and to some extent operated by members of the academic staff (i.e. the faculty), who are drawn from medical, nursing and/or other health care disciplines. Faculty health services may be owned by the university, or a specific school, or an amalgam of interested parties; they may include substantial physical facilities or none at all, and may or may not be located on the university campus. Services may be of a general or highly specialized nature, and may or may not be exclusively nursing-run. When run by nurses, they are widely referred to as *nursing centers* (National League for Nursing 1989) and much of the U.S. literature uses that term (Barger 1995), including that associated with the influential Penn-Macy Initiative described below.

The nursing faculty at the Medical College of Georgia viewed FP as including “consultation, administration, and education activities,” but no explicit scholarship requirement (Williamson, McDonough & Boettcher 1990, p.16). Fifteen years later, at the University of Massachusetts School of Nursing, FP is defined rather more narrowly as “. . .direct care services for clients and consultation and educational experiences that support the provision of direct care and education of students, providers and consumers.” (University of Massachusetts School of Nursing 2005).

The paper by Saxe, Burgel, Stringari-Murray, et al. (2004) is devoted to the problem of defining this type of FP. They say that, “Most faculty practices share the following elements:

- there is a formal contractual arrangement, with a defined focus and clear boundaries;
- patient care is the central focus of the teaching/ practice/service/research activities;

- clinical scholarship is a key outcome;
- clinician, educator, researcher, consultant, and/or administrator roles are visible in the settings; and,
- faculty practice sites provide additional resources, in addition to funding already allocated for teaching. (Algase 1986; Budden 1994; Ford & Kitzman 1983; Potash & Taylor 1993; Taylor 1996)” (ibid., pp.166-167)

The authors note that the “broad and inclusive faculty practice definition from the National Organization of Nurse Practitioner Faculties (NONPF) is commonly accepted by advanced practice nursing educators to guide faculty practice development, namely:

Faculty practice includes all aspects of the delivery of health care through the roles of clinician, educator, researcher, consultant, and administrator. Faculty practice activities within this framework encompass direct nursing services to individuals and groups, as well as technical assistance and consultation to individuals, families, groups, and communities. In addition to the provision of service, the practice provides opportunities for promotion, tenure, merit, and revenue generation. A distinguishing characteristic of faculty practice within the School of Nursing is the belief that teaching, research, practice, and service must be closely integrated to achieve excellence. Faculty practice provides the vehicle through which faculty implement these missions. There is an assumption that student practica and residencies as well as research opportunities for faculty and students are an established component of faculty practice. (Saxe, Burgel, Stringari-Murray, et al. 2004, p.167)

This remains the definition preferred by NONPF (<http://www.nonpf.com/>).

A number of models of FP emerged during the 1990s (e.g. Barger & Kline 1993; McNeil & Makey 1995; Potash & Taylor 1993), and Hutelmyer and Donnelly (1996) described three organizational models for bringing practice and education together: the unification, collaboration and dyad models. In the *unification model*, the head of the school of nursing is also the Director of Nursing for the clinical agency comprising the FP, which is staffed by nurse academics. In the *collaboration model*, a variety of joint appointments between the university and the clinical service are established, along with agreements as to time commitments, mutual responsibilities and sharing of costs. This is contrasted with the *dyad model*, which involves shared services, and joint involvement in research, education and clinical practice, but no financial exchange, costs are absorbed independently by each agency.

More recently, the four models described by Potash and Taylor (1993), and adopted by the NONPF, have been modified slightly by Saxe, Burgel, Stringari-Murray, et al. (2004), as follows:

1. *entrepreneurial or linkage model*, in which academic staff develop their own practice roles as part of their scholarly activity, and all academics have an explicit clinical role; this corresponds very closely with the Australian FP concept;
2. *private practice model*, in which academic staff develop their own private practice separately from their academic roles;

3. *integration or nursing center model*, in which academic staff and graduate students share patient care responsibilities;
4. *unification model*, in which the school of nursing and the clinical agency share the same administration; and,
5. *collaboration or joint appointment model*.

In summary, the health care services provided by academic staff may amount to private practice or subsumed in their university employment, and may or may not attract the normal fees from service users. There is a substantial literature relating to this form of health service, including consideration of its value (e.g. Barger & Bridges 1990; Gale 1998; Rudy et al. 1995) and management (e.g. Barger 1995; Cohen & Cox 2003; Henry 1997; McNeil & Mackey 1995). Services are often offered at favourable rates to underserved populations (Pollock & Biester 1994; Sebastian & Stanhope 2003), also serve as clinical placements or learning contexts for student clinicians, and provide opportunities for research and scholarship development (Zacharia & Lundeen 1997), clinical innovation and the development of leadership skills (Lang, Evans & Swan 2002).

By far the largest proportion of the published literature on FP concerns this type of arrangement and, although it is not the main focus of this review, which concentrates on FP as it is understood in the Australian context, it offers a valuable resource. A few U.S. schools of nursing operate both types of FP: the University of Texas Health Science Center at Houston explicitly operates both types (McNeil, Mackey & Sherwood 2004). FP, as understood in Australia, takes place in both models.

2.3 Faculty Practice as Clinical Practice by Academics

As noted above, FP refers to something slightly different in the context of Australian nursing, but the two concept overlap because the American system offers one way in which the Australian notion can be realised. Here it refers rather to any arrangement by which academic staff employed by a university participate in clinical practice in health care settings outside the university, usually *pro gratis* and as one strategy for keeping up to date and bridging the gap between theory and practice.

This concept of FP is consistent with the definition given by Broussard, Delahoussaye, & Poirrier (1996, p.84): “nursing care given to clients that is focused on a particular population ...or nursing problem. ...that is aimed at improvement of nursing care in a larger context, and that informs the faculty member’s research and teaching roles”.

This type of FP involves academic staff engaging in clinical roles, and this has been formally recognised to varying degrees. In some cases it has been associated with a range of hybrid job titles, such as Joint Appointee, Lecturer-practitioner, Practitioner-lecturer, Liaison-lecturer, Practice Dean, and Clinical Professor. How these have been defined and operationalized will be reserved for the discussion below. Broadly, joint appointees (JAs) are

nurses employed by, and undertaking work responsibilities, for two employers, clinical and educational: costs are normally shared in a way that corresponds to the distribution of the appointee's time between the two agencies, which is usually equally divided (Acorn 1988; Wyness & Starzomski 1989).

2.4 Faculty Practice in Order to Maintain Clinical Skills

Some concepts of FP refer only to the efforts of academic staff to maintain or develop their clinical skills. Just, Adams, & DeYoung (1989, p.165) took this further and argued that "faculty practice describes those activities that maintain clinical skills and promote scholarship thereby resulting in improvement of patient care and the advancement of nursing science". Potash & Taylor (1993, p.2), note that the National Organization of Nurse Practitioner Faculties (NONPF) expanded this definition yet further to include "all aspects of the delivery of nursing service through the roles of clinician, educator, researcher, consultant, and administrator".

However, staff could do this by maintaining a private practice, for example, or ad hoc work in clinical settings. Thus, Acorn (1991, p.221) noted that faculty practice was taken by some authors to include "private practices and group practices (Frazer 1980; Free & Mills 1985; Rasmussen 1984)", and that "[m]oonlighting ...practice on a part-time basis in a position separate from their faculty role, is another form of faculty practice (Diers, 1980)". However, most commentators do not regard such activities as constituting FP. In an early paper, Fagin, for example, argued that "research must result from any endeavor in which faculty are engaged. Faculty practice designs that do not reflect the research agenda are doomed from the start" (Fagin 1986, p.144). Academic staff may practice within various relationships, but practicing within a second, paid position "not contracted through a school of nursing" is "moonlighting" and does not constitute FP (Anderson & Pierson 1983, p.132; Polifroni & Schmalenberg 1985; Rodgers 1986). Hodgman also notes (1991, p.311) that "Batey (1983) does not consider either practice within a second position or practice to maintain clinical skills as faculty practice".

In view of such differences of opinion, Hodgman (1991) suggested that FP was such an ambiguous term that authors using it feel compelled to provide their personal definitions. For her own part, Hodgman expressed support for McClure's (1987, p.163) argument that FP "be viewed as a matter of individual (faculty) intent". "This aspect of the definition is important", she says, "because it dictates where one looks for opportunities. When one sees faculty practice as a matter of individual intent, greater numbers of options may be explored and tested" (1991, *ibid.*, p.312). McClure (1987, p.162) argues that "in an applied discipline, faculty practice consists of doing what you teach others to do. In this context, practice connotes the focus and intent to study, improve and master both the substance and process, including the technical aspects of delivering nursing care." Hodgman (*ibid.*) points out that this places FP within the domain of continuing education, and sees it is a compelling rationale, noting that faculty members themselves have identified this need (Franklin 1980; Kuhn 1982; Eschbach 1983; O'Neill 1985; Ossler, Goodwin, Mariani & Gilles 1982; Polifroni & Schmalenberg 1985; Sharkey & Elliott 1988).

Nevertheless, Hodgman (ibid.) admits that “Organizational intent must also be factored into the definition”, and it is now widely accepted that in order to constitute FP, clinical activities need to be part of a formally organized faculty programme and subsumed into academic workloads, to embrace the scholarly objectives of the school, and to reflect the mission statements of the university. Thus, NONPF proposed guidelines referring to an institutional model of FP which conceived it as part of a formal institutional mission, and included support for faculty role integration, enhanced nursing control and fiscal autonomy, and mechanisms to evaluate health care outcomes (Marion 1997).

Dracup (2004, p.175) reiterates that a “faculty member who engages in clinical practice to augment salary and/or to *maintain clinical expertise* (for example, working on weekends or in summer months as a nurse practitioner) is not engaged in the narrow definition of faculty practice used in this discussion. The university is usually excluded from any contractual arrangement and education of students is not included in the faculty member’s clinical role.” This has become the orthodox view.

3. Faculty Practice as Faculty Health Services

3.1 Faculty Health Services Outside Australia

Faculty practice has represented both an enticing promise and a thorny problem to nursing education for many years, and the literature goes back at least as far as 1981. The early history of faculty practice, and the associated literature, has been reviewed in detail at different stages (Barger, Nugent & Bridges 1992; Broussard, Delahoussaye & Poirrier 1996; Chickadonz 1987). Barger, Nugent and Bridges (1992) note that although efforts to unify nursing education and practice “began with Smith’s (1964) efforts at the University of Florida in the 1950s and were continued by Schlotfeldt (Fagin, 1985) at Case Western Reserve, Christman (1979) at Rush, and Ford (Ford & Kitzman, 1983) at the University of Rochester in the 1970s, it was not until the 1980s that everyone began talking about faculty practice” (Barger, Nugent & Bridges 1992, p.264). This is consistent with Hodgman’s (1991, p.310) observation that a growing concern to “. . . legitimize nursing practice as an integral part of the faculty role” received authoritative expression in 1979 through the widely published *Statement of Belief Regarding Faculty Practice*, signed by eleven deans of baccalaureate and higher degree programs in nursing and others (Statement 1979). This tied faculty practice to the unification of nursing service and nursing education, as it is generally agreed that faculty’s movement away from direct care provision is an historical outcome of the “service-education split.”

Barger, Nugent & Bridges (1992, p.264) describe the next stage of development as follows:

Concentration on the issue of faculty practice was made possible by a grant from the Robert Wood Johnson Foundation to the American Nurses Foundation, which funded four symposia on

faculty practice (Barnard, 1983; Barnard & Smith, 1985; Feetham & Malasanos, 1986). Cosponsored with the American Academy of Nursing, these symposia were held in 1983, 1985, 1986, and 1987. Through these conferences and the resulting publication of their papers, the philosophical, theoretical, and practical issues of faculty practice were described, explored, and analyzed. Noticeably absent were research on faculty practice. Similarly, the faculty practice literature of the 1980s was largely philosophical and descriptive in nature. Beginning with Mauksch's (1980) seminal article, "Faculty Practice: A Professional Imperative", faculty practice was exhorted as a vital role component for nursing educators.

Arguments in favour of FP had been considered persuasive, and it was widely established across the United States. Health services operated by schools of nursing had been established from the early 1980s (Boettcher 1996) and took various forms, including mobile clinics, aged care facilities, walk-in clinics in the community, and campus-based clinics (Shiber & D'Lugoff 2002, p.81). However, after reviewing the FP literature Barger, Nugent & Bridges (1992) concluded that philosophical support and initial enthusiasm were beginning to be reined in by growing concerns about faculty role overload. By the end of the 1980s, FP had become a controversial topic, and Just et al. (1989) described it as "extensively debated" and yet without consensus as to definition, purpose, or value.

As a result, from the mid-1990s, the literature explored, evaluated and defended the existence of faculty-led nursing clinics (Barger 1995; Gersten-Rothenberg 1998; Macnee 1999). A long-standing complicating factor in this development has been the relationship of such clinics and their clients to the national Medicaid system of health funding. Few had become financially independent: a 1990 survey found that, typically, c.50% of funding came from the school itself (Barger & Bridges 1990) and Mackey & McNeil (1997) later found that they were still largely underwritten by the universities and charitable grants. In a political context informed by economic rationalism, this funding situation has at least called their future into question. A number of authors have noted specific problematic aspects of expenditure (Boettcher 1996; Ervin, Chang & White 1998; Vincent et al, 1999), and several models and creative programmes have been described which are aimed at surviving cost-benefit analysis (Evans, Swan & Lang 2003; Gale 1998; Lang & Evans 1999; Mackey & McNeil 1997; McIntosh et al. 2003; McNeil & Mackey 1995; Shiber & D'Lugoff 2002; Swan & Evans 2001).

The relation of FP to federal and state policies in the U.S. is discussed briefly by Edwards (2002), but is otherwise a neglected issue in the literature.

Certainly, in the United States, faculty health services provide important services to the community and have become a key element in the profile of university schools of nursing. It is difficult to understand the comment by Lang, Evans and Swan (2002, p.64), reporting on the important Penn-Macy collaboration, that "Few schools of nursing operate clinical practices". The extent and success of FPs are taken as indicative of the status of the school and its staff, and they play an important part in attracting high calibre staff and students, as well as research funding from government and other agencies.

A good example of a large university-health service collaborative arrangement is the Penn-Macy Initiative developed by the School of Nursing at University of Pennsylvania (Evans, Swan & Lang 2003; Lang, Evans & Swan 2002; Lang, et al. 2004; Swan & Evans 2001). The

background to the initiative is summed up by Lang et al. (2002, p.64) as follows:

Since the 1970s, the school has embarked on practice partnerships and faculty practices. Since 1995, under the umbrella of the Penn Nursing Network (PNN), the school has launched and operated a range of community-based clinical practices (Evans et al., 1999; Lang et al., 1996; Naylor & Buhler-Wilkerson, 1999). Through PNN, advanced practice nurses provide best practice models of community-based, family-focused health care services to people of all ages in a variety of settings—from newborns to the frail elderly—with emphasis on vulnerable populations. Services have ranged from primary care and health promotion to tertiary care in the community. They have included nurse midwifery, well-child care, preteen and adolescent care, family planning, women’s health, primary care for children and adults, continence, gerontologic consultation, and, for frail older adults, comprehensive rehabilitation and integrated acute and long-term care. The practices also have spanned the full continuum of organizational and financial arrangements, from fee for service to fully capitated and blends of both.

Because of this initiative, the School at the University of Pennsylvania has become a recognized leader in the development of cross-system partnerships and has consultative arrangements with many other Schools across the country (Lang et al. 2004).

The following is a brief selection of FP arrangements currently in place in U.S. universities.

- The faculty health services at the University of South Carolina are typical of a large U.S. university, and the relevant policies and procedures are made available through the School’s website (<http://www.sc.edu/nursing/FacPractPolProced2004.pdf>);
- The College of Nursing at the Medical University of South Carolina has an Office of Faculty Practice, and a statement of its ‘conceptual model’ and ‘practice overview’ are available on the School’s website (<http://www.musc.edu/nursing/>);
- Campbell et al. (2001) describe the creation of the partnership between the Mennonite College of Nursing at Illinois State University and the local medical center, and illustrate the range of spin-off initiatives which can arise, including a shared research programme;
- An instructive paper by Saxe, Burgel, Collins-Bride, et al. (2004) reports the systematic development of FPs by the University of California, San Francisco (UCSF) since 1995, detailing the funding and contractual arrangements, the number of clinical visits to each site, and the type of service and clientele. Humphreys et al. (2004) describe recent developments in the paediatric service acquired by UCSF in 1993, which is owned and managed by the School of Nursing, and is described as playing an essential role in the practice, teaching and research roles of the School’s academic staff. UCSF now has perhaps the most significant faculty health provision of any school of nursing, and its importance is evident from perusing the relevant webpages and documents provided by the school (see: <http://nurseweb.ucsf.edu/www/fpgd.htm>¹). UCSF epitomizes the successful integration of academic and service activities;
- early partnership developments at the Vanderbilt University School of Nursing, Tennessee, were described by Norman, McArthur and Miles (2001); it presently has a nursing-midwifery practice devoted to women’s health, including a full range of perinatal, obstetrical and gynaecological services (<http://www.vanderbiltnursemidwives.org/>);
- The School of Nursing at the University of Texas Medical Branch operates a Student Wellness Center and a Center for Healing Practices, as well as a range of FP arrangements with local health services

(http://www.son.utmb.edu/practice/faculty_practice.htm);

- The University of Texas Health Sciences Center at Houston, School of Nursing operates two models of FP, one in which academic staff go into a clinical setting of their choice, by negotiation with the agency, and one in which the School manages and staffs a primary care and occupational health service (McNiel, Mackey & Sherwood 2004);
- The School at the University of Michigan has an extensive range of academic-service partnerships, and a dedicated ‘Office of Community Partnerships’, and its website offers a range of downloadable FP statements (<http://www.nursing.umich.edu/ocp/fpp.html>);
- the Institute for Johns Hopkins Nursing (<http://www.ijhn.jhmi.edu/>) is a partnership between the Johns Hopkins University School of Nursing and the Johns Hopkins Hospital Department of Nursing, and its early development has been described by Sabatier (2002);
- Barger and Das (2004) similarly describe a collaboration – a “winning partnership” - between the University of Alabama and local health providers which subsumes and extends FP to include a variety of cooperative service development projects, including leadership development, education programmes, the creation of a computerized medical record system, and RN refreshers courses;
- Krothe et al. (2000) describe the impact of a community-academic partnership that led to the development of a nurse-managed clinic for an underserved population in a rural Indiana, which demonstrates how even comparatively small faculty health services can help meet community and academic needs and have a significant impact; similarly,
- Persily (2004) describes an “exemplar” of FP involving West Virginia University School of Nursing in the creation of a much-needed rural pre-natal service.²

There is huge diversity in services provided under the umbrella of FP in the U.S., covering virtually all specialties, including peri-natal and midwifery care (e.g. Ament 2004; Nichols 1985), paediatrics (Gance-Cleveland & Gilbert 2001; Jordan 1994), aged care, mental health (e.g. Chafetz, Collins-Bride & White 2004), in-patient forensic services (e.g. Appelbaum, Manning & Noonan 2002), community corrections (Sadler, Huff & Harrigan 2000), and substance abuse services.

¹ The pdf documents generously made available at this site, including the *Faculty Practice Policy & Procedures Manual*, and several academic articles by UCSF staff, could not be successfully downloaded when consulted on 18th August 2005. This was communicated to the relevant UCSF school authority, but they remain inaccessible.

² the position statement by American Association of Colleges of Nursing (2002) describes nearly 40 strategic academic-service partnerships, and provides web links and references

The value of faculty health services is suggested by the fact that in addition to their expansion, they continue to be promoted, developed and proposed in the literature. Ryan-Nicholls (2005) notes several problems being encountered at the School of Health Studies at Brandon University, Canada, namely the desire of staff to engage in clinical practice, a shortage of clinical placements for psychiatric nursing students, and a shortfall in certain psychiatric services. She argues that these problems could be resolved by creating a multi-sector partnership with a view to establishing a campus-based mental health clinic.

3.2 Faculty Health Services in Australia

The only example, that could be identified, of a health service provided directly by nurse academics in Australian universities is that of the 'Mobile Community Health Unit, which operated from 1988 onwards and was run entirely by staff from Deakin University's Warrnambool campus, Victoria. Funded by a grant from the Victorian Post-Secondary Education Commission, the unit was a large, specially adapted caravan, which operated across rural Western Victoria. Services were of a general nature but included mental health, such as suicide prevention, stress management and marital problems. Data was collected with a view to research, and was fed back to local health services.³ A reduction in staff numbers, and the cost of having the caravan renovated, forced the project's cessation in 1998.

3.3 Benefits of Faculty Health Services

In addition to the benefits associated with academic staff undertaking clinical practice, which are reviewed later in this report, the specific benefits of providing faculty health services are widely said to include:

1. an opportunity to develop and test new approaches to care delivery;
2. an opportunity to develop a range of management and leadership skills;
3. an setting in which to conduct quality nursing research;
4. provision of a safe and controlled clinical placement option for nursing and other students, where high quality learning may take place; and,
5. a service to the community, in keeping with the mission of the university.

Although widely taken as a strong rationale for the development of faculty health services, the evidence that these benefits are realised in practice is at best equivocal. Another, less widely claimed benefit of faculty health services is that they enhance the quality of education experienced by students. Once again, whilst reasonable arguments can be adumbrated to support this claim, it has received little research attention and the evidence remains primarily anecdotal (e.g. Good & Schubert 2001) or embedded within promotional material produced by individual schools of nursing.

³ I am grateful to Ms Pat Nesbitt of the Warrnambool campus of Deakin University for this information.

The American Association of Colleges of Nursing (AACN) supports the development of strategic academic-service partnerships (AACN 1997, 1999, 2002), and sees them as a means of creating a well-educated nursing workforce capable of working in complex university hospital settings (AACN 2003). However, given the complexity of nursing recruitment and retention processes, it is not surprising that it is not possible to locate hard empirical evidence

that such partnerships play a significant role. The progressive nature of participating institutions, the ethos of quality care, and the increased funding that is involved, may account for good recruitment and retention statistics, rather than the partnership itself. The AACN does not cite research evidence when articulating its position.

Dracup (2004, p.177) describe the faculty health service (FP) as “a living laboratory for evidenced-based practice.” However, she adds (ibid.) that “Being able to use faculty practices to meet the research mission of a university requires uniform data collection techniques and a commitment to creating the informatics structure necessary to collect and store data.” The evidence suggests that staff involved in the provision of faculty health services are more likely to become involved in research, than they were beforehand, but it is not clear whether increases in activity are likely to be sustained beyond an initial ‘honeymoon’ period, or that they do not simply represent a systemic shift in research focus rather than an overall increase. There is substantial evidence – notably the accounts of the development of such services in particular U.S. universities - to suggest that research undertaken in the context of a faculty health service is more likely to attract substantial funding than research based in the academy. It is not possible to determine the level of FP-based research emanating from U.S. schools of nursing, or to assess the effect FP has on research funding and output.

Dracup (2004, p.177), declares that, “...a successful faculty practice provides an unparalleled opportunity for teaching students in undergraduate and graduate programs about the essentials of nursing clinical practice.” However, whilst this appears to be a logical conclusion, little empirical evidence is available to confirm that faculty health services strengthen the clinical focus of nurse education, or that they improve the preparation of nurses for clinical practice. Hence, in relation to their study, Saxe, Burgel, Collins-Bride, et al. (2004, p.181) noted that although “there was a perception that students had rich learning experiences in the academic faculty practices, there were no data to support this supposition.”

As illustrated above, in some cases, faculty health services target underserved or neglected populations, and there can be no doubting the benefit to the community. It is not possible to identify research reports which demonstrate that the extra funding required to create and sustain these partnerships could not be used more effectively by being directed at meeting those same needs through conventional services. Nevertheless, it could be argued that if it were not for a faculty practice initiative, these needs would continue to be neglected. In other words, faculty health services raise the profile of marginalized groups and their health needs, as well as effectively making some provision for them which would not otherwise be available.

3.4 Drawbacks and Problems Relating to Faculty Health Services

A range of problems arising in relation to the provision of faculty nursing services have long been recognized (Barger, Nugent & Bridges 1992; Walker, Starck, & McNeil 1994). They are widely acknowledged to concern:

- the negotiation of mutually acceptable contractual arrangements between the university and overseeing agency; universities usually provide a specialist or niche service which forms part of a wider public or private health service; disagreements may arise, for example, over the nature and extent of the service to be provided, how it will be operationalized, where it will be located, how it will be funded, the role of academic and other staff, capital and continuing expenditures, accountability and liability issues, operating procedures, and medium and long-term planning;
- the disparate nature of the aims, objectives and motivations of the overseeing agency, the university and individual academic staff; many staff become disillusioned with faculty practice, even when undertaken in a faculty nursing service, because they find that expectations regarding throughput and rapid turnover can not be reconciled to their desire to provide high quality, time-consuming care;
- the cost involved in resourcing the service, especially since the preferences of the academic staff are that the service should be aimed at impoverished, marginalized and neglected groups who are not in a position to pay for services; and,
- recognition of clinical practice as a legitimate element in the academic portfolio of university staff.

Whilst it is crucial that FP services exemplify high quality and a strong client orientation (McNiel, Mackey & Sherwood 2004), Dracup (2004, p.176) notes that, “One of the most formidable issues facing most faculty practices is financial sustainability.”

Millonig (1986), while identifying the benefits of faculty practice, also identified the following barriers: (1) the time needed for practice conflicts with time needed for teaching and scholarly pursuits, (2) difficulties obtaining appropriate and acceptable practice sites, (3) barriers to reimbursement of faculty for practice, (4) conflicts of commitment to both the educational and practice setting, and (5) limited recognition for faculty practice in the promotion and tenure area. Furthermore, she identifies a barrier that is “in some way related to all of the other barriers” (1986, p.170), the barrier of role strain.

3.4.1 Role Strain and Conflict

In an early paper, Wakefield-Fisher (1983) identified potential sources of role strain when the expectation of practice is added to the current role obligations of nurse educators and questioned whether FP was a realistic expectation. Other authors, such as Neely et al. (1986), contended that practice should be viewed as an integral part of the academic role and not as a burdensome ‘extra’. The study by Steele (1991) examined the opinions and beliefs of academic staff (N=345) regarding FP and their perceptions of role and role strain. Those engaged in FP ranked practice higher in importance than did other academics, and ranked

research as less important. They believed that being actively involved in the clinical area increased their teaching effectiveness and scholarly productivity, and reported less role strain and more confidence in other aspects of the academic role. No evidence was sought to test these perceptions, however. The study by Lambert and Lambert (1993) examined the relationships of role stress and psychological hardiness among educators (N=871) employed full-time in a National League for Nursing (NLN) accredited school of nursing with both undergraduate and graduate programs. No significant difference was found in reported role stress or in measures of psychological hardiness between nurse educators involved and those not involved in faculty practice.

Whichever position is adopted, several potential sources of strain and conflict for staff engaging in FP can be identified and are widely reported, notably:

1. the problematic place of clinical practice in the role expectations and value systems of the university;
2. the disjunction between the roles and values associated with an academic culture and those of the clinical environment; and,
3. the increased demands that FP places on individual resources, especially their time, energy and enthusiasm.

Traditionally, the role of the university academic has been conceived in terms of 'scholarship', comprising teaching, research and service to the university. Whether and how clinical practice undertaken by academic staff constitutes "scholarship" remains a matter of dispute, to the extent that it creates significant role strain for those involved. Some universities see FP as separate from scholarship, and from their core business, so that staff are extending their roles and responsibilities without institutional recognition, to the extent that they may be disadvantaged in relation to formal evaluation of their performance.

The study by Herr (1989), involving nurse educators in public nursing programs in 15 states in the southern region of the U.S., indicated that staff were more receptive than resistant to the proposal that faculty practice become a requirement for promotion and tenure. However, Burns (1997) notes that FP has rarely been recognized as an activity meriting tenure. Thus, the survey of American nursing schools by Barger, Nugent and Bridges (1992), for example, found that over 80% of schools using FP did not include practice in their criteria for promotion and tenure. This situation is consistently reported in FP literature (e.g. Rudy et al. 1995, p.79), and remains a matter of concern. A survey by the NONPF (Pohl 1999, cited in NONPF 2000; Pohl et al. 2002) found that 50% (n = 210 academics) of the respondents indicated that practice was not considered in either promotion or tenure, and that practice was given less weighting than teaching and research in promotion and tenure decisions. Twelve years later, Dracup (2004, p.175), found it necessary to argue that "university promotion committees must be encouraged to look at the academic portfolios of faculty engaged in significant amounts of clinical practice in new ways or the faculty will be disadvantaged when compared to that faculty not engaged in direct clinical practice", a point made by a

succession of commentators over the last two decades, including Budden (1996), Forni and Welch (1987), Sherwen (1998) and Wright (1993).

Sherwen (1998, p.138), writing in respect of the implications of FP for nurse education in American liberal arts colleges, argued that practice and scholarship can not be separated. Sherwen pointed out that there was some recognition of this in the statements of other disciplines, and that a 1991 survey of 113 United States medical school deans found that 78% (88) had changed or were in the process of changing promotion criteria to give increased recognition to clinical practice, and that promotion criteria had been widely revised along similar lines (Bickel 1991). Sherwen's paper draws attention to the reflexive relationship between theory and practice described by Schön (1983) and others (Rice & Richlin 1993). "Several corollaries emerge from this perspective. First, education for the professions should be organized around problems of practice. Second, students must be provided with opportunities to reflect during practice and about practice. Third, evaluation of students and practicing professionals must include assessment of performance in complex situations of actual practice" (Sherwen 1998, p.139). However, that practice contributes to theory is hardly in dispute, and the real question is whether a person who teaches needs to be in practice. They can, after all, learn from the practice of others, and utilize the research findings that are generated from practice; and we may ask whether it is reasonable to expect the same individual to be involved in each component of this process.

Sherwen's paper focusses, however, on the concept of scholarship and its relation to clinical practice, drawing on the model described in the influential monograph *Scholarship Reconsidered: Priorities of the Professoriate* (Boyer 1990). This model identifies four modes of scholarship, based on a critique of the traditional conception, arising out of a disparity between university work and the expectations and needs of the community. In particular, Boyer argues that the academy has allowed a gap to develop between its values and expectations, and those of the professions it serves, and that the link between the concerns of the professions and the needs of the community have been weakened. The way to address this is to reconfigure 'scholarship' so as to include 'scholarly practice', in which "theory and practice reinforce and strengthen each other", so that it "both applies and contributes to knowledge." (Sherwen 1998, p.139) This notion of scholarly practice has been developed by Lynton (1995) and Starck (1996), and is cited a number of times in the FP literature (e.g. Newland & Truglio-Londrigan 2003, p.270). Sherwen concludes by summarizing the benefits of scholarly FP. That practice and theory should stand in a reflexive relationship has been widely argued in nursing literature and, according to Sherwen (*ibid.*, p.140), "Practice by academic nursing faculty is the primary means of bridging the gap between education, practice, and theory."

The study by Tolve (1999) found that significant role conflict and fragmentation was experienced by academic staff trying to balance teaching, research, university service and clinical roles. This is supported by Sawyer et al. (2000), following an analysis of 35 leading papers on faculty health service provision: they concluded that integration of practitioner, educator and researcher roles was extremely difficult and sometimes impossible. This role conflict may have origins in the self-attributions of academic staff in university schools of nursing, for whom lifelong commitment to nursing as a practice discipline entails a self-

image still subordinated to a practice role. Thus, a frequently noted reason for engaging in FP is a desire on the part of academic staff to engage in clinical practice. Pegram and Robinson (2002, p.34), for example, say that “On a personal level the experience of faculty practice goes some way to address the dissonance that motivated nurse teachers, i.e. the incongruence in saying ‘I’m a nurse, I teach nursing but I don’t do nursing’.” However, we might reasonably ask why these staff do not instead say ‘I am an academic, and I do teaching, research and all the other work of academics’. The motivation to undertake FP is inevitably expressed in terms of a personal desire to return to ‘hands-on’ practice, and never in terms of a desire to bridge the gap between theory and practice, for example, to be up to date, to develop and test new approaches to care, to conduct research, or to develop leadership skills.

The empirical evidence that lecturers regard clinical practice as a desirable addition to their role is equivocal. The U.K. studies by Davies et al. (1996) and Phillips et al. (1996), for example, suggested that they do not, whereas the study by Murphy (1998) (N=196) suggests that they do. However, anecdotally, the passion that many academic staff have for nursing practice is well-known, and evident in the literature, and their desire to engage in FP could reasonably be interpreted in terms of nostalgia, an attempt to return to the excitement, and sense of mastery and fulfilment that they enjoyed through clinical practice, before becoming employees of the university. There are a number of observations which are consistent with this suggestion:

- the academic role of nurses working in university schools does not sit comfortably with many;
- there is a widespread feeling that they are undervalued and even exploited within the university setting, a feeling which tends to make the past – their work in the clinical setting – appear more attractive; and,
- the constant attention in the literature to the disparity between theory (their work in the university) and practice (their work in the clinical setting), may be, in part, an expression of this feeling; this concern does not assume the same proportions in other, comparable disciplines

In their recent review of the literature on faculty nursing services, Saxe, Burgel, Collins-Bride, et al. (2004, p.183) found that:

The challenges from the literature, and validated through faculty interviews, include:

1. Limited time for faculty to fulfil their obligations in the areas of practice, teaching and scholarship,
2. limited funding opportunities for faculty practice (especially for core operating support),
3. conflicts in the commitment between the community service agency and the university,
4. limited recognition for faculty practice within the context of promotion and tenure, and
5. difficulties posed by financial and contractual arrangements. (9,10,11)

Writing in respect of the University of California, San Francisco, these authors state that:

Historically ...nursing faculty practice arrangements were typically developed from an individual faculty interest and specialty program perspective, not from a broader organizational

perspective. A clear faculty practice mission statement, consistent with broader academic mission and operations, and the [University] Department's vision, became essential to guide the development of the strategic planning goals, objectives, activities and outcomes.

A theme which surfaces in the FP literature in all its forms, across all countries, and from the earliest reports to the present day is the problem of overload. Academics engaging in FP, joint appointees, clinical professors, and so on, all report the tendency to gradually acquire a greater and greater clinical load, without respite from university-based responsibilities. Many people who have first-hand experience of these roles describe themselves not only as 'working for two masters' but as 'doing two jobs', and burnout is a widely reported danger.

Again, time constraints led Rodgers (1986) to be sceptical of the practicality of FP, given the fact that at the time of writing, most nurse academics were planning to begin doctoral studies in order to further legitimate their place in the academy. She argued that adding practice and doctoral study to existing academic role requirements of teaching, research and service, would result in chronic overload.

3.4.2 Institutional Support and Conflicting Ideology

Academic organisations have been reluctant to practically support FP initiatives, whether of the American service type or the Anglo-Australian experiential/hybrid role type.

In the U.S., a study by Barger, Nugent & Bridges (1992, p.269) found that "Institutional supports for faculty practice, such as faculty practice plans and formalized practice arrangements, were in evidence in only approximately one fourth of the schools in this study." Problems over institutional support and funding were again highlighted by the American Association of Colleges of Nursing (1993), and noted by Walker et al. (1994) and Andreoli (1993).

Culbertson (1997) found that executives running managed health care services were uniformly reluctant to embrace the changes, or meet the costs, that accommodating FP by health care professionals would entail. This is problematic in the U.S. since academic departments increasingly retain independence by relying on clinical income, and principally income from the provision of health care services. As a consequence of financial pressures, faculty health services are now being run explicitly as business ventures (Swan 2004; Swan & Lang 2001; Vincent et al. 2001).

4. Faculty Practice as Clinical Work by Academic Staff

4.1 Faculty Practice Outside Australia

Faculty led health services clearly offer one means by which FP as clinical activity by academic staff can be realized. A key idea behind the provision of FP as faculty health services in the U.S. is *academic nursing practice*, and the two concepts developed together.

Ford and Kitzman (1983), were notable among many authors who argued that, in order to maintain the currency and relevance of nurse education, academic staff should maintain clinical competence by engaging in clinical practice. This idea, and ways in which it might be operationalized, was developed at a symposium held by the American Academy of Nursing (Barnard & Smith 1985), and elaborated at subsequent symposia (Feetham & Malasanos 1986). This line of development led to a concept of academic nursing practice which is similar to the FP concept as it appears in Australia, but operationalized through faculty health services.

Academic nursing practice is not consistently conceptualized, however, and there are many definitions. Persily (2004, p.75), for example, defines academic nursing practice as an activity, "...the purposeful integration of education, research and clinical care in an academic setting to advance the science and shape the structure and quality of health care." She goes on to use the term academic nursing practice to refer to any clinical practice that takes place in such an environment, and student nurses are described as engaging in *academic faculty practice*. Thus, it refers to any clinical practice which takes place in the context of a faculty practice, i.e. within a faculty-led health service. However, it is also clear that the term is used as a noun, to describe a faculty health service run by nurses (e.g. Sebastian, Mosley & Bleich 2004), and in this sense is synonymous with the term *academic nursing center*, which is also widely used (e.g. Barger & Bridges 1990; Humphreys et al. 2004; Mackey & McNiel 1997; McNiel, Mackey & Sherwood 2004; Shiber & D'Lugoff 2002). Bailey (1995) uses the variant *academic nursing care center*, and describes her work in the center as 'faculty practice'. Despite the confusion, many U.S. authors continue to prefer the term 'academic nursing practice' (Evans, Jenkins, & Buhler-Wilkerson 1999; Miller et al. 2004), including those associated with the Penn-Macy Initiative (Evans & Lang 2004; Lang et al. 2004; Swan & Evans 2001).

Some American nursing authors use the more general term *academic faculty practice* to refer to the participation of academic staff in clinical practice, wherever that might take place (e.g. Brown 2001; University of Washington School of Nursing 2003; University of Washington School of Nursing Practice Committee 2000). This can be achieved through a range of FP scenarios, including having academic staff contracted out to clinical agencies, maintenance of a private practice, work in faculty practice clinics as described above, and a variety of hybrid academic-clinician appointments. A careful scan of the web pages of U.S. schools of nursing suggests that these arrangements tend to arise when substantive faculty health service provision is not possible.

The Australian concept of FP, in which academic staff systematically engage in regular clinical practice in a local health service has been referred to only occasionally in the American literature. For example:

- Miller (1997) employs the Australian concept but suggests that it includes an on-site teaching role and extends it to include the formal provision of 'continuing nurse education'.
- FP is stated by DiMarco (2000) to be regarded by the University of Akron, Ohio, as "an integral part of the mission of the College of Nursing", and she

describes FP at a shelter for homeless women and children. Staff of the College spend an average of 8 hours per week in practice at the shelter.

- As noted several times earlier, the School of Nursing at the University of Texas Health Science Center, Houston, is one of the few schools to explicitly operate both types of FP (McNiel, Mackey & Sherwood 2004).

Likewise, in the U.K., this notion of FP, as distinct from the LP role, is also rarely discussed. One example is that of Allen (2000), who describes her FP in a community health care context.

4.2 Faculty Practice in Australia

FP appears to have been introduced into Australian universities by the Faculty of Nursing⁴ at Deakin University during 1987/88. All academic staff in the Faculty were required to work 20% of their time as a clinician. This was written into employment contracts and was reflected in some staff titles, notably “Lecturer-Clinician”. Contrasting with, and complementing, this arrangement were the joint appointees, entitled “Clinician-Lecturer”, who undertook 80% clinical practice and 20% academic work. The arguments upon which this was based are familiar – the need to be “up-to-date” and to be “in touch” with the world of clinical practice. Being “in touch” was considered important for two reasons: 1) to remind the academic of the realities of clinical practice, and 2) to show clinicians that academics are not isolated in an ‘ivory tower’ but are part of the ‘real’ world of nursing. There was no formal reporting or monitoring of FP, however, and no expectation that it would result in collaborative research or scholarly outputs; this was not surprising, since most staff were still studying to obtain basic research qualifications at that time. Under its Foundation Chair of Nursing, Professor Alan Pearson, Deakin University also established the country’s first Professorial Nursing Units, located in local hospitals and based on Pearson’s success with such units in England. These tended to serve as the focus for scholarly outputs linked to practice, and worked closely with the Institute of Nursing Research, also part of the Faculty of Nursing.

⁴ At various times, Deakin University has had a “Faculty of Nursing” and a “School of Nursing”. As far as possible, this report uses whichever term was correct at the time concerned.

FP was also adopted in other Australian universities. Millican (1995), a lecturer at La Trobe University, Melbourne, described her FP in detail and drew up a list of basic requirements for successful FP, drawing on conditions laid out by Polifroni and Schmalenberg (1985) in respect of their nurse-consultancy roles, namely:

1. obtain approval and legitimation from the senior levels of the hospital and the university;
2. obtain positional authority;

3. allow details of timing, shift and workload to the individuals directly involved;
4. continually report and evaluate so as to demonstrate the continuing value of the role; and,
5. ensure non-interference in the clinical setting by the university.

Today, it appears that:

- most Australian Schools of Nursing do not have FP policies;
- although widely encouraged, FP is not a requirement of academic staff in any Australian university;
- FP is not factored into the workloads of Australian nursing academics; and,
- few Australian nursing academics actively engage in FP.

A few schools have FP policies already in place, a number are interested in developing such policies, and several intend to finalize FP policies during 2006. At least one university is intending to introduce FP as an integral part of the role expectation of academic staff. In some cases, there is no FP policy but there is a mutual understanding that FP can be undertaken.

By way of, examples:⁵

- Charles Sturt University staff have the option of undertaking 20 days FP per year;
- Curtin University staff are encouraged to undertake up to two weeks FP per year;
- Flinders University, and Australian Catholic University (Vic.) staff may engage in FP, provided it is outside teaching periods; this is not monitored or factored into workloads;
- La Trobe University staff are expected to undertake two weeks FP per year, but this is not monitored or factored into workloads;
- University of Newcastle staff undertake FP by working self-initiated casual shifts in local health services;
- The Tasmanian School of Nursing formed a collaborative association with the Department of Health and Human Services in 1998, called “Partners in Health”, by signing of a Statement of Mutual Intent (revised 20 August 2003).⁶ The association is aimed at “coordinating and integrating teaching, research and clinical service delivery to enable more efficient operations and better value at a time of significant financial pressure.” In order to fulfil these aims, “staff of the University seek to undertake faculty practice in nominated areas of the Department’s facilities”. The Statement details arrangements for indemnity insurance, legal liabilities, and

remuneration issues, and requires individual applications to be made, with approval from the Department subject to appropriate credentialing.

In a few universities, staff undertake clinical practice at weekends, during their study leave or other leave periods, as a way of keeping in touch with practice. This is entirely on the initiative of individual staff and is not a formal arrangement involving the School, and is not monitored or evaluated. As noted earlier, such activities come under the category of 'moonlighting', and despite the intentions of those concerned, is not usually regarded as constituting FP.

A variety of innovative collaborative arrangements with health providers are evident in Australian universities, and the academic-clinical interface is entrusted to a wide range of creative cross-over appointments. However, no Australian university could be identified, at the time of writing, as operating systematic FP which is built into academic position descriptions, factored into workloads, monitored, evaluated, or credited as part of the scholarly work of the school. None could be identified in which FP was an element in mission statements or philosophies, or an agreed indicator for the purposes of institutional or individual performance review.

⁵ I am grateful for the generous advice and information that I received from the Heads of Schools in Australian universities; I have sought to respect confidentiality and have refrained from indicating the extent and nature of FP activities actually undertaken in particular Schools.

⁶ Relevant documents and progress reports can be found via the 'Partners in Health' website: <http://www.healthsci.utas.edu.au/pih/index.html>

It can be safely concluded that in most Schools, there is no FP activity of any kind. The likely reasons for this are discussed in Sec.4.4 below.

4.3 Benefits of Faculty Practice

The benefits of FP have been repeated many times in the literature (e.g. Rudy et al. 1995, p.80), and usually include claims that FP:

1. enables academics to keep abreast of recent developments in clinical practice;
2. strengthens the clinical focus of nurse education so that nurses are adequately prepared for clinical practice;
3. nursing is a practice discipline and so those who teach it should be practitioners;
4. justifies re-registration of academic staff as Registered Nurses, which may be a requirement imposed by bodies responsible for approving certain nursing courses;

5. provides an opportunity to conduct of clinical research;
6. provides an opportunity to demonstrate clinical skills to students and colleagues; and,
7. represents a tangible contribution of the university, the nursing school and the academic staff to the health and well-being of members of the community, particularly to those who are disenfranchised, marginalized or under-served.

The evidence that these benefits actually accrue in practice is generally weak, however, and most of the literature asserting such benefits relies on personal accounts and subjective impressions. It was not possible to locate rigorous research demonstrating these benefits.

4.3.1 Keeping Up-to-date

In the United Kingdom, it has been strongly argued that this is a major imperative for the adoption of FP strategies. Thus Pegram & Robinson (2002, p.31) note: “The general assumption appears to be that service managers and staff believe nursing and midwifery lecturers lack up-to-date knowledge and clinical credibility” Certainly, the U.K. reports (e.g. Department of Health 2000; UKCC 1999a, 1999b) indicate that lecturers are regarded by government departments as needing regular access to clinical practice for the maintenance and development of clinical expertise. Thus, the UKCC (1999) insists that:

It is essential that teachers not only have knowledge, teaching and academic credibility but also clinical credibility in respect of their capacity to teach the art and science of nursing. (p. 48)

While Pegram and Robinson (ibid.) conclude that “Action therefore is imperative”, none of the sources cited by them or the Department provide research evidence to support these declarations, and the claim that the practice world is the place to encounter the latest innovations in practice needs to be qualified.

The latest *bona fide* developments in clinical practice are those reported in the international academic literature, which is the recognised forum through which they may be evaluated and elaborated, and such developments may only slowly find their way into the everyday practice world. At the level of the individual clinician, there is strong evidence that they do not read these reports and, indeed, that they have extremely low rates of accessing any type of academic journal. At the institutional level, formal mechanisms for systematically assessing and implementing clinical innovations are almost non-existent in many, perhaps most, clinical organizations. Furthermore, academics are necessarily in close touch with the literature, and likely to be familiar with a range of developments which have not yet found their way into the local practice arena. The expectation that academics themselves contribute to that literature entails such familiarity.

It is reasonable to expect that academic staff would be up-to-date if they work in a culture in which scholarship is valued, knowledge is shared and there is a general expectation that they will keep abreast of developments in their chosen specialties. Even if it is conceded that

academics may become out-of-date in terms of their knowledge of practice, regular clinical work in a local setting may not address the problem, and more effective strategies may be available, such as conference participation, participation in research programmes, secondment to centres of excellence in their field, and co-authorship of clinically focussed, academic reports and papers.

Indeed, it is possible that FP becomes a dispiriting experience for some academics because they encounter interventions which they know from the international academic literature do not represent the latest or most effective available.

This highlights a contradiction in the supposed advantages of FP. If, indeed, FP in a local clinical setting serves to keep academics up-to-date they are clearly settings at the cutting edge of practice, in which case they will hardly benefit from the out-dated knowledge of the academic! This cuts across another oft cited claim, that FP offers an opportunity for academics to make a useful contribution to practice, facilitate expert practice in others, introduce clinical innovations, and develop leadership skills.

4.3.2 Strengthening the Clinical Focus and Quality of Nurse Education

The Council of Deans and Heads of UK Faculties of Nursing, Midwifery and Health Visiting (1998) took the view that the development of JAs, LPs and other collaborative arrangements should be encouraged, not only as a way of addressing the theory-practice gap, but because “A University with a substantial body of clinically focussed teaching staff is likely to be more successful at producing students who learn practice relevant skills” (ibid., pages unnumbered). In support of this claim, it cited only the ENB study of pre-registration undergraduate degrees in nursing and midwifery by Phillips et al. (1996), which is out of print and no longer available on-line.

4.3.3 Nursing is a Practice Discipline, and That Goes for Those who Teach it!

As an argument for FP, this claim contains two major premises: first, that nursing is a practice discipline; and, second, that academics in nursing schools all teach nursing. It is the orthodox view that “Nursing is a practice based discipline and the primary objective of education in the profession is education for practice” (McFarlane 1976, cited in Holland 2002, p.148). According to Pegram and Robinson (2002, p.31) “In a very real sense it seems unimaginable to those outside nursing that teachers of a practice-based discipline, are themselves, not engaged in practice in a coherent and meaningful way.” Here, the rationale for FP is located in public opinion about nurse educators, but there are two objections to this: firstly, public opinion, and a barely disguised populist appeal to ‘commonsense’, do not constitute reasons for a cogent standpoint on the issue; secondly, no evidence is presented that such an opinion exists, which is especially ironic situation in this case, given that there is a simultaneous appeal to nursing’s status as an evidence-based profession.

In her powerful note of approval of Recommendation 20 in the *National Review of Nursing*

Education (Heath Report 2002, p.24) that FP should be an expectation of Australian nurse academics, McMurray (2003, p.6) noted the claim of Lissan (1994) that “to believe one can teach what one cannot practice is logically inconsistent”. As a general claim, this does not appear to be the case since there are many cases in which a person may cease to be able to practice a particular skill and yet be a valuable and effective teacher of that skill. More importantly, however, it assumes that nursing is a practice discipline and that all teaching is directed at skill development. But it might be argued that ‘knowing what’ and ‘knowing why’ are as important as ‘knowing how’. In other words, knowledge acquisition, the development of insight and understanding, and the refinement of attitudes and values, are as important as the acquisition of clinical skills. Indeed, the subordinate position of nursing in the health care system, and with it the dissatisfaction felt by many nurses, and both acknowledged and evident in McMurray’s article, can be traced in part to the institutionalized neglect of these aspects of being a professional, reflective practitioner.

It is not clear why nursing should be framed exclusively as a “practice-based discipline”, and why this should be any more the case than it is for other academic disciplines, such as law, history, or mathematics. In addition to skills acquisition, nursing as a university-based discipline encompasses specialist areas of scholarship which may be primarily aimed at increasing the understanding not only of those skills but also of nursing’s theory, history and research. Nursing in the context of the modern university is a discipline which encompasses a wide variety of scholarly activities which do not require familiarity with, or experience of, clinical issues.⁷ Among these might be counted academics who specialize in research methodology and supervision, the history, economics and politics of nursing, nursing management and service delivery models, nursing informatics, nursing philosophy, nursing leadership and bioethics. In addition, some staff obviously carry significant administrative and managerial workloads, and in some cases teaching may be only a minor component of their work. Whilst nursing is a practice discipline for the practising nurse, it is substantially more than this for the academic. This suggests that although FP might be useful for certain staff working in schools of nursing, for others it might be an inappropriate and even unwelcome distraction from their core academic roles.

4.3.4 Justifying Re-registration of Academic Staff as Registered Nurses

If recent clinical practice were a requirement for continued registration, some form of FP, or private practice, would be essential if nurse educators wished to be eligible. However, no British or Australian nurse registering body at present requires evidence of recent clinical practice for an individual to be eligible to remain on the register, and educational, managerial and research practice are accepted alternatives.

Furthermore, there is no statutory requirement for nurse educators in university schools of nursing to have their names appear on the nursing register. There appears to be a strong expectation that they maintain their registration, however, and it may be a condition for approval of courses leading to registration, by the registering authorities, that they are overseen and largely taught by nurses whose names appear on the register. Unless nurse academics are engaging in clinical practice, however, there appears to be no good reason for expecting them to maintain their registration. Indeed, it might be asked how authorities can

justify the continuing registration of non-practising nurses, if their position is that nursing is a practice discipline. The explanation that can be culled from official statements of the registering bodies is that, for the purposes of continuing registration, “nursing practice” includes management, teaching, research and so on.

4.3.5 Providing Opportunities for Clinical Research

It is reasonable to expect that FP would result in increased opportunities for co-operative research activities involving clinical staff of a variety of disciplines, and for nurse academics to become involved in funded research. However, there appears to be little empirical evidence to suggest that nurse academics engaging in FP actually engage in more research than they would otherwise do, that they attract increased levels of research funding, or that they are more likely to publish. There appears to be no published research establishing the relationship between FP and research productivity.

⁷ It is significant that important contributions to scholarly work in relation to nursing – both in Australia and elsewhere - have been made by academics who have had little clinical experience, no recent clinical experience, or are actually not nurses at all. Dr. Denise Polit, for example, the principal author of the world’s biggest selling and most influential nursing research textbook, dating back over 25 years, and translated into many languages, is not a nurse and has no clinical experience of any kind.

4.3.6 Providing Opportunities to Demonstrate Clinical Skills

Whilst being located in a clinical setting obviously enables academic staff to demonstrate clinical skills under real conditions rather than the artificial conditions of the academy, there does not appear to be any empirical evidence to suggest that academics are more skilled clinicians than regular staff. Indeed, there is some evidence in the literature that since they are only occasional practitioners, they may require some degree of advice and support, especially in relation to less commonly exercised skills, and especially when first returning to practice. Likewise, there is no clear evidence that skills teaching by academics during FP is especially effective, or results in better skills acquisition by students. Indeed, the research evidence on this issue is so scant as to preclude a systematic review.

4.3.7 Contributing to the Health of the Community

No empirical evidence could be located on the subject of the benefits of FP to the community. Unlike the U.S. system of faculty-run health services, its benefits to the community are thus unclear, and may have more salience for the academic concerned than for the community or for patients. The amount of time committed to practice is typically very small and, whilst individuals may appreciate this involvement, only in exceptional cases will significant contributions to the health service or general well-being of the community emerge.

4.4 Drawbacks and Problems Relating to Faculty Practice

Many of the drawbacks and problems raised earlier in the discussion of faculty health services in the U.S. apply also to the general issue of academic staff undertaking regular

clinical practice, including FP as it is conceived in Australia. They may be even more difficult to resolve, however, since, in Australia at least:

- the university, and school, have no involvement in the management or administration of the clinical setting and are therefore unable to deal directly with issues arising;
- the clinical setting remains ideologically and attitudinally separate from the academy and is not so directly open to change and innovation;
- university authorities may be unable or unwilling to release staff for FP, because of university downsizing, staff shortages and the pressure of existing workloads; this is regarded by McMurray (2003), among many others, as the main impediment to making FP an expectation in Australia;
- individual nurse academics themselves, regardless of their opinion as to the value of FP, may feel that they simply can not add yet another burden to what is already felt to be an excessive and unsustainable workload, a point raised by a number of commentators (e.g. Daly 2003);
- university authorities may be unable or unwilling to accept a situation in which they see the university as paying to help local health services provide care, effectively subsidizing local state-funded services;
- the resource implications of effectively reducing the time spent in on-site work of university academics by diverting them to the clinical field have not been addressed, and prospects for compensatory resources do not appear promising in the present financial and political climate;
- university authorities and nurse academics are under pressure to increase research and other scholarly outputs; income to the university and to nursing schools is tied to those activities; overall, nursing still under-performs in these areas, and so any diversion of effort to clinical practice would seem inappropriate and may be unwelcome by all parties;
- Daly (2003) raises a host of questions regarding the administration and regulation of FP; in particular, there would need to be standards established in order to conduct fair and accurate performance appraisals of staff in respect of their FP, as an integral component of their academic role; arrangements would need to be in place for the assessment of the academic staff member's clinical competency, and for their ongoing clinical supervision; issues relating to indemnity insurance, and its funding, would also need to be resolved;.

In addition, some Heads of Schools in Australia have stated⁸ that FP is problematic because:

- increasingly restrictive budget constraints mean that Schools can not afford to provide more than the essential on-site teaching that is required to successfully run the courses that are offered; there are a variety of reasons, political, economic and professional, why the universities are concerned to ensure that the schools are working to maximum capacity as far as the numbers of undergraduate students is concerned;⁹
- factoring FP into workloads is difficult when staff are already working at full stretch, and finalizing existing workload agreements has itself been problematic;
- it is difficult to make out a case to trades unions and other bodies representing university staff for having FP anything more than optional, because of the additional burden that it entails; an additional burden which, furthermore, would be without salary compensation;
- it is difficult to establish insurance arrangements; existing policies in some universities and health care services preclude academic staff from providing direct ‘hands on’ care, including psychological care and counselling; one reason for this is that an academic undertaking FP is not an employee of the clinical agency; and,
- staff have generally been unable to demonstrate unequivocal benefits from their FP activities, and thus can not be justified in light of the costs involved and the competing demands.

⁸ in personal communications with the author

⁹ Reasons include the relationship between these numbers and income to the school, the increasing demand for Registered Nurses, and the expectations of professional and political authorities. The general lack of support in universities for FP, is reflected in the United Kingdom. Pegram & Robinson (2002), for example, noted that “the UKCC (1999) suggest that higher education institutions (HEIs) have failed to support the role of lecturers in practice and classroom teaching is made a priority (Day et al. 1998).”

5. Faculty Practice Through Joint Appointees and Other Hybrid Roles

5.1 Development and Role of Joint Appointees (‘JAs’) and Lecturer Practitioners (‘LPs’)

From nursing’s earliest days, clinicians adopted educational roles. In many countries around the world, the task of teaching clinical skills to student nurses largely rested with practising

nurses, usually the Ward Sister or Charge Nurse, and was seen as a professional responsibility, often explicit in clinicians' role descriptions.

However, during the 1970s this began to change in America, as major developments of the 1960s – such as primary nursing, masters' level education, nurse practitioner roles and the nursing process – began to have an impact (Newland & Truglio-Londrigan 2003). In other countries, similar developments occurred a few years later. As nursing moved into the 1980s, workloads increased and health service managers and nursing staff became more discriminating about what constituted a 'nursing' task, and were increasingly reluctant to commit valuable clinical time to *in-vivo* teaching. In some countries, the change was accelerated by the move of nurse education from hospital-based facilities to colleges and universities. This effectively spelt the end of the 'apprenticeship' model, and teaching began to disappear from the clinical role. It was increasingly assigned, on a part-time or full-time basis, to designated individuals. Today, clinicians are increasingly likely to hold those individuals, and/or the academy, wholly responsible for ensuring that nurses, whether students or otherwise, have the skills needed to do the job.

In the United States, a plethora of strategies for combining teaching and practice roles emerged during the 1970s, along with a confusion of role titles in the nursing literature this including *joint appointments*, also called *adjunct appointments* or *shared appointments*¹⁰ (Arpin 1981; Diers 1980; Joel 1985; Royle & Crooks 1985). Christman (1979) described a *Practitioner-Teacher*, a member of academic staff who teaches and practices in the clinical setting, and virtually synonymous with the *Clinician-Educator* (Fagin 1987; Kruger 1985). The term practitioner-teacher is also used by some authors (e.g. Mallik 1993; Mason & Jinks 1994) to describe the British *Lecturer Practitioner* role, which is discussed in detail below. The *Clinical Associate* is a clinically expert nurse, employed by a health service, who holds an academic title and implements learning and research activities (DeVoogd & Saltenblatt 1989).¹¹ Kruger (1985) describes how she began working as a joint appointee, and when the contract finally ended, she then continued working in the same clinical setting – a paediatric unit – by means of an Australian-style FP arrangement.

Just, Adams and DeYoung (1989) described three models of FP that summarized these joint appointment innovations, the *Nurse-Researcher Model*, *Nurse-Clinician Model*, and *Nurse-Consultant Model*. Donnelly, Warfel and Wolf (1994) describe several hybrid roles in the context of a faculty health service developed jointly by a school of nursing and a local health provider. Research joint appointments have emerged, for example, in which nursing schools have established *Director of Nursing Research* positions as a joint appointment with the clinical agency, sharing costs and benefits (Newland & Truglio-Londrigan 2003, p.270).

In Canada, a 1988 survey of degree-granting institutions found that ten reported the use of joint academic-clinical appointments (Acorn 1988), and Strang et al. (1999) found that they tended to act as brokers, interpreting the cultures of each agency to the other, thereby increasing opportunities for mutual understanding and collaborative initiatives. JAs are not always locate in a hospital setting and are reported as working in clinics and the community, and in midwifery as well as nursing. At the University of Alberta, for example, JAs work in the provision of home care (Ogilvie, Strang, Hayes, et al. (2004). Ogilvie, et al. (2004)

summarize the developments in Canada over the last two decades.

The literature also refers to the *Clinical Education Facilitator* (Becket & Wall 1985; Ellis & Hogard 2001, 2003; Kelly, Simpson & Brown 2002; Lambert & Glacken 2005; Rowan & Barber 2000; Salvoni 2001), and the *Practice Placement Facilitator* (PPF) (Clarke et al. 2003). Again, their role is hospital or health service based, and is directed at the support of student nurses during clinical placements, particularly in the acquisition of clinical skills. The accounts in the literature do not refer to appointees having direct clinical responsibilities.

¹⁰ The earliest paper referring to 'joint appointments' appears to be that of Pierik (1973).

¹¹ Outside nursing, Bullough et al. (2004) have described *Partnership Facilitator* roles in relation to teaching, and a *Clinical Faculty Associate* (CFA) role, both very similar to roles in nursing.

In the United Kingdom, *joint appointments* in nursing date back to the suggestions contained in the Briggs Report (1972) and the Royal Commission on the National Health Service (1979). Ashworth and Castledine (1980) published what appears to be the first paper describing JAs, and in 1981, a trial JA was created at the West Cumberland Hospital, as evaluated in detail by Balogh and Bond (1984). A notable JA in the early 1980s was that of Steve Wright at Thameside General Hospital (Salvoni 2001, p.65). The idea was that a nurse would hold a dual role, clinical and educational, that is shared between the service side and the hospital's School of Nursing, or Education Department. Wright came to the view that the only way in which such a joint appointee could be effective in changing attitudes and establishing a quality learning environment was for the holder to be a senior nurse (Wright 1988).

With the increasing role of universities in British nurse education, this idea transmuted into that of the *Liaison-lecturer* and *Lecturer-practitioner* ('LP')¹². Liaison-lecturers work on an *ad hoc* basis, as time allows, in a clinical setting on behalf of the academy, advising clinicians about educational and staff development issues, monitoring the experience and progress of students assigned to that setting, and acting as a conduit for the exchange of information between the two organisations. Significantly, they do not generally have time to engage in any clinical practice. Stevens (1994) also described a variant role, the *Collegiate Lecturer-practitioner*.

The emergence of the LP concept in the U.K. has been described by Lathlean (1992, 1995) and began with suggestions articulated by Barbara Vaughan (Vaughan 1987, 1989) for bridging the TPG (theory-practice gap), constituting a 'joint appointment', and entailing formal arrangements to spend fixed amounts of time in the academy and in an identified clinical practice role. LP positions in nursing first became a reality in Oxford during the late 1980s, under the auspices of Barbara Vaughan and Judith Lathlean in Oxford (Lathlean & Vaughan 1994),¹³ and it was a former colleague of Vaughan's, Professor Alan Pearson, who introduced university joint appointments into Deakin University during 1987/88. It is significant, however, that JAs had already been operating in at least one other Australian university (Emden 1986).

The nature of the developments at Deakin University was described in the collection by Lathlean and Vaughan (1994), by Cox, Hanna and Peart (1994) and Cox (1994) who

depicted the LP role in terms of a 20% commitment to FP. These positions were funded exclusively by the university. In the same text, Hanna and Peart (1994) described the role of the *Clinician-lecturer*, who had an inverse commitment, i.e. 80% clinical, while Cox, Hanna and Peart (1994) described the role of the jointly-funded JA at Deakin.

¹² A literature search of the term “lecturer-practitioner”, using Google Scholar, yields some 200 references. Only those which are most frequently cited and which address issues specific to the remit of this review have been consulted here.

¹³ Within a decade, there were over 70 LPs in Oxfordshire and the role has been widely embraced by British health trusts (Shepherd, Thomson, Davies & Whittaker 1998, p.374). A survey conducted almost a decade ago by Hollingworth (1997) found that 42% of health trusts employed LPs.

¹⁴ LPs in the United Kingdom are now commonplace and have a substantial presence. They work in a variety of settings and specialties, including accident and emergency (Wright 1988), critical care (Richardson & Turnock 2003), intensive care (Lloyd Jones 1993), oncology (McPhail 1997), cardiac care (Davies 2004), orthopaedics (Ousey 2002), mental health (Gould & Crookes 1996), learning disability, midwifery (Lessing-Turner 1997) and – albeit rarely – in the community (Shepherd et al. 1999). Reviews of nursing and the health care disciplines in the U.K. have consistently called for the appointment of JAs and LPs to be speeded up (e.g. Department of Health 1999a, pp.27-28, 1999b), albeit without reference to any empirical evidence as to their value.

¹⁵ LPs are also to be found in a wide variety of disciplines, including medicine, pharmacy¹⁵, teaching, engineering, management, law, theology, and social work, and the small study by Fairbrother and Mathers (2004) found a high degree of commonality between the disciplines in relation to the problems that the role entails. There are also LPs in physiotherapy education (Hargreaves & Hewison 2002), and Stevenson, Chadwick and Hunter (2004) found similar problems and needs among this group. ¹⁶ The review by Bullough et al. (2004) suggests that they also characterize JAs in the context of collaborative arrangements between U.S. university education departments and local schools.

¹⁷ Champion’s (1991) ¹⁷ summary of the four models of LP operating in Oxford at that time focus on clinical management roles and do not mention lecturing, the university or the nursing school/education department. On the other hand, Elcock (1998, p.1095) noted that the British literature is “almost unanimous in describing the need for the LP to have direct patient contact(Burns 1994; Champion 1991; Dearmun 1993; Garbett 1995; Gould & Crooks 1996; Guilfoyle 1990; Lathlean 1992, 1995; McNally 1994; Rhead & Strange 1996; Stitt 1995; Stringer 1995; Vaughan 1987, 1990; Woodrow 1994a)”. However, exactly what that “patient contact” comprises is not made clear in the literature and the accounts of the role in the literature suggests that it includes little or no ‘hands on’ clinical care (e.g. Camsooksai 2002), which is somewhat at odds with the rationales usually underpinning FP.

Most of the detail in the literature concerns the LP role in supporting and teaching students in clinical settings. This is reflected in the paper by Elcock (1998), who provided a valuable concept analysis, based on a systematic and critical review of the published literature, catalogued a variety of definitions and models, and noted the various rationales that have

been prompted their development. She makes it clear that the LP was widely conceived as physically based in the clinical setting, and says nothing about their academic or scholarly responsibilities. This is typical of the literature generally, which has almost nothing to say about the involvement of LPs in the academy, about the professional and vocational benefits to the appointee, or about their role in relation to research, clinical innovation or skills enhancement, or the development or exercise of administrative, managerial or leadership skills. Ironically, the research role of the LP was the subject of the thesis by Fitzgerald (1989), who evaluated the potential of the LP as a leader of action research. Elcock (1998) concluded that the notion of the LP is a source of much confusion

¹⁴ The multidisciplinary National Lecturer Practitioner Forum, located at <http://www.nlpf.org.uk/>, was set up in 1994 as a focal point for LP initiatives, and is headed by Professor George Castledine and Chaired by Pat Fairbrother, whose publications are cited in this report.

¹⁵ Warner & Gerrett (2005, p.204) refer to the LP as “the traditional model” in pharmacy education.

¹⁶ It is noteworthy that the reference list provided by Stevenson, Chadwick and Hunter (2004), and the physiotherapy Lecturer-Practitioner website at Keele University (http://www.keele.ac.uk/depts/pt/groups/lect_pract/home.htm) comprises mostly nursing publications.

¹⁷ cited in Elcock (1998, p.1094; original unpublished)

Fairbrother and Ford (1998) reviewed the role of LPs in practice and found that although they undertook lecturing and work in the clinical setting, there was confusion and uncertainty about what these roles entailed and how they were to be fulfilled. A subsequent study came to the same conclusion (Aston, Mallik, Day, Fraser & Collaborative Research Group 2000). Despite ambiguities and uncertainties as to the role, the Department of Health, repeatedly emphasizing the need for the “theory-practice gap” in nursing to be bridged (Department of Health 1999a, 1999b), called for more joint appointments, often linking them to new ‘Nurse Consultant’ posts. The principal aim was to increase practice-based teaching, particularly in relation to undergraduate training.

Fairbrother and Ford (1998, p.274) noted that, as with the FP concept, the LP role was at that time developing in a haphazard way to suit the needs of each health agency, influenced by the personal views of commentators, local needs, the expertise that happened to be available. As with FP, this approach has its supporters (e.g. Childs 1995) and its critics (e.g. Lee 1993).

Subsequently, Camsooksai (2002, p.469) summed up the role by defining the LP as:

...a joint appointment between a hospital/NHS trust and a university with a responsibility for education - in academia and in practice. The overall aim usually covers the education and the support of professional development of the nurses within a clinical area. Usually there is also involvement or responsibility for clinical development within that area.

In an important paper, Williamson (2004) provides the first systematic review of the research conducted into the role of the LP in nursing and midwifery, and tabulates the details of 14 empirical studies. The main themes that emerge are summarized in **Table 1** below. A consistent finding is that LPs see their role in the clinical setting in terms of supporting post-registration clinicians, often with a view to improving the academic culture in which pre-registration students would be placed, rather than supporting pre-registration students directly or engaging in ‘hands-on’ clinical practice. Scholarly output, research, and academic roles

within the university are subsidiary to these functions.

Williamson (2004, p.788) notes that:

The relationship between LPs and nurse consultants is still not clear, but it is likely that both could become elements in an emerging 'clinical academic' career pathway, giving nurses the opportunity to move between practice and education settings without abandoning clinical practice (Council of Deans and Heads of UK University Faculties of Nursing, Midwifery and Health Visiting, 1999; Andrewes, 2002). This would maintain academic and clinical expertise, each without detriment to the other.

It remains unclear, however, how this clinical academic pathway would allow the dual roles to be sustained "each without detriment to the other", as Williamson claims.

Table 1: Synthesis of findings from research on the role of Lecturer-Practitioner (Williamson 2004, p.794)

Concept References

Theory–practice gap? Lathlean (1992, 1996), Hemphill et al. (1996), McCrea et al. (1998), Driver and Campbell (2000), Redwood et al. (2002)

Complex role; requires particular skills Jones (1996), Nelson and McSherry (2002), Redwood et al. (2002)

Support is important Jones (1996), Williamson and Webb (2001), Nelson and McSherry (2002)

'Link role' is important Jones (1996), Fairbrother and Ford (1997), Day et al. (1998), McCrea et al. (1998), Redwood et al. (2002)

Serving two masters/ role conflicts Hemphill et al. (1996), Fairbrother and Ford (1997), Hollingworth (1997), McCrea et al. (1998), Shepherd et al. (1999), Williamson and Webb (2001), Nelson and McSherry (2002)

Lacks clarity Hemphill et al. (1996), Fairbrother and Ford (1997), Day et al. (1998), Williamson and Webb (2001)

Roles not adequately reviewed Hemphill et al. (1996), Fairbrother and Ford (1997), Williamson and Webb (2001)

Research/evidence-based practice role McGee (1998), Williamson and Webb (2001), Redwood et al. (2002)

Staff development role McGee (1998), Williamson and Webb (2001)

Regular meetings required between managers McCrea et al. (1998), Williamson and Webb (2001), Redwood et al. (2002)

Clinical credibility Shepherd et al. (1999), Driver and Campbell (2000), Nelson and McSherry (2002)

Potentially stressful and Hemphill et al. (1996), Shepherd et al. (1999) causing burnout

5.2 Specific Types of Hybrid and Joint Appointments

It may be useful to briefly review the plethora of role titles and concepts that have surfaced in relation to hybrid or ‘cross-over’ roles at the interface of nursing education and clinical practice.

Clinical Teachers were introduced in the United Kingdom in 1955, and were formerly called *Clinical Instructors* (Fairbrother & Ford 1998, p.275). Post holders were formally qualified and appointed as Registered Clinical Nurse Teachers (RCNT), and were distinguished from those qualified and appointed as Registered Nurse Tutor (RNT). *Nurse Tutors* were based exclusively in the education setting, whereas the *Nurse Teacher* also worked in the clinical setting. Although located in the clinical setting, clinical teachers did not carry a direct patient care load. With the changes in nurse education, which moved it much closer to a tertiary system, their position became highly problematic (Baillie 1994; Burke 1993; Cave 1994; Clifford 1993a, 1993b, 1996; Crotty 1993a, 1993b, 1993c, 1993c; Davies et al. 1996; Gerrish 1992; Ioannides 1999; Lee 1996; Luker, Carlisle & Kirk 1995; Osborne 1991), and the LP role which then emerged was largely a revision of this position. By 1994, three different types of joint appointment were said to be operating in the U.K. (Mason & Jinks 1994), i.e. the Lecturer Practitioner, the Clinical Facilitator, and the Senior Nurse in Practice Development.

Clinical facilitators represent a significant bridge between the academy and the clinical setting, and are employed primarily to “teach nursing student nurses clinical skills in the academic setting, and to support and enhance such practices within the clinical setting” (Salvoni 2001, p.67). The ethnographic study undertaken by Hogard (2002) aimed to evaluate the work of these facilitators, using in-depth interviews and questionnaires distributed among clinical colleagues, managers and students (N=760). She found that clinical facilitators were ranked the second most useful individuals to students on placement, behind the designated “assessor mentor” but well ahead of the “university link tutor”. In a recent paper, the author describes a “communication audit” designed to improve all aspects of communication involving clinical facilitators and students on clinical placements (Hogard et al. 2005).

Concerning the notion of a *senior nurse in practice development*, Salvoni’s (2001) article includes the following description of the author’s own such appointment:

As a joint appointment, the writer was employed 2 years ago as a Senior Lecturer in Practice Development holding employment status at University College Worcester. The partnership at Worcester Royal Infirmary NHS Trust encompassed the role of Professional Head of service for one of the Directorates within the Trust. The vision for establishing such a role was to create an alliance between the two organizations whereby the key areas of responsibility

included:

- Support policy and strategy development within the clinical domain
- Promote evidence-based practice
- Undertake ward audits
- Facilitate and extend the research culture and activities
- Support clinical staff in the development of practice
- Undertake teaching and research activities.

However, by 1998, the English National Board study of nurse teachers and lecturers found that “the most common label applied to the role is *Link Teacher/Lecturer*” (Day, Fraser, Mallik, et al. 1998, p.2).

In pursuance of its standards for the preparation of teachers of nursing, midwifery and health visiting (UKCC, 2000), the U.K. subsequently adopted a new role and job title, alongside that of Lecturer, the *Practice Educator*. “The term ‘practice educator’ is used to denote the role of the teacher of nursing, midwifery or health visiting who makes a significant contribution to education in the practice setting, co-ordinating student experiences and assessment of learning. The practice educator leads the development of practice and provides support and guidance to mentors and others who contribute to the student’s experience in practice enabling students to meet learning outcomes and develop appropriate competencies” (English National Board & Department of Health 2001, p.6). The Practice Educator is conceived as someone with “unique opportunities for integrating theory and practice, initiating and using research in practice and developing practice for improved patient/client care in a multiprofessional context” (ibid.). Since September 2001, there has been only one approved teaching qualification recorded by the U.K.’s regulatory body for nursing, midwifery and health visiting in respect of the practice educator and/or the lecturer qualification.

Castledine (2001), who has been a leading figure in nurse education in England for many years, believed that the key to the future was the development of a new type of clinical teacher who would work with students in practice. He emphasized the need for major investment, in order to avoid what sees as an impending crisis situation in practice placements. The work of Clarke et al. (2003) supports this call for major investment, and outlines the unprecedented demands on clinical areas and staff. They highlight what they view as the crucial consequence of this situation, namely reduced time and staff available to supervise students, and the subsequent compromise of clinical teaching and learning.

Perhaps because of this sense of crisis, the U.K. has gone on to develop a range of roles that combine teaching and practice. The School of Health, Nursing and Midwifery of the University of Paisley, Scotland, for example, has *Clinical Faculty* (unusually using the word ‘faculty’ in its American sense) who provide both clinical instruction to students and direct patient care. Clinical Faculty enjoy the privileges of membership of the School, and are given three-year contracts, but remain in the employ of the health service. They are equivalent to the ‘adjunct’ staff in the Australian system, discussed below, and may include staff at any level of appointment.

... Inherent within this remit under the umbrella of practice development emerged the need to expand areas of health care policy, practice, research and the development of nurses. The role was a new concept in terms of what was perceived as managerial. It therefore offered a degree of freedom to shape and develop the post which has proven to be challenging though well supported by immediate managers. (Salvoni 2001, pp.67-68)

Salvoni does not refer to direct patient care, nor any clinical responsibility, as being part of this role.¹⁸

Whatever form the joint appointment takes, post holders are usually employees of the university and effectively seconded to the clinical area, or vice-versa, for a proportion of their time, and a financial exchange is made between the two organizations. However, joint appointments are also common in which the individual has an *honorary joint appointee* role in the setting in which they are not normally employed. A senior clinician may be made an *honorary lecturer*, for example, or – more rarely – a senior academic may have an honorary role as a clinician. Such arrangements are commonplace in medicine. In nursing, there is usually no financial exchange involved in honorary appointments and, although there may be benefits in terms of access to facilities and resources, the principle benefits are collegial and professional. They are widely referred to in Australia as *adjunct appointments* and represent a significant way in which practising clinicians bring their experience to the educational setting.

Newman, Hayes and Sugden (2001) report the operation, at one London University, of a series of *Senior Lecturer Practitioner* (SLP) positions:

- the SLP1, commenced in 1998; appointed on basis of clinical specialism (dementia care); jointly funded by the university (80%) and a local “not-for-profit” private health care agency (20%);
- the SLP2, appointed on basis of clinical specialism (aged care); jointly funded by the university (60%) and an NHS Trust (40%); and,
- the SLP3, operated 1996-99, appointed because of methodological expertise; jointly funded by the University Research Centre (50%) and an NHS Trust (50%).

While the SLP1 works alongside staff who are providing hands on care, direct care is not included in the role descriptions of any of these appointees. The SLP2 provides a quality improvement role, helping the clinical setting in which they work to adopt evidence-based practices, along with action plans, monitoring and self-assessment strategies. The SLP3 worked with managers to help establish organisational pathways for the adoption of evidence-based practice and conducted relevant action research.

A consultation paper by the Council of Deans and Heads of UK University Faculties of Nursing, Midwifery and Health Visiting (1999) refers to the *Clinical Dean*, which it describes as an individual in a Trust or Health Board who takes responsibility for the provision of suitable student experiences while they are placed in the NHS. They are usually senior staff, respected clinicians and employees of the NHS, holding an honorary appointment with a University. Since ‘Clinical Dean’ is a familiar title to teaching Trusts and Health Boards, the paper argues, it might do no harm to adopt the title for nurses or midwives

offering a similar responsibility. The paper also suggests that it might be the case that clinical deans will be the ‘consultant nurses’ appointed by the NHS.

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It is puzzling that Salvoni adds, as a passing comment, that the role is “different from that of a lecturer-practitioner where no direct patient care is encompassed” (Salvoni 2001, p.69).

The demands of responsibility for staffing, managing and/or owning a faculty-based health service are substantial and have led to the creation of new substantive positions within American schools of nursing which are similar to those described here. Furthering the discourse which refers to academic nursing practices, Sebastian, Mosley and Bleich (2004) describe the development, of the *Academic Nursing Practice Dean* (ANPD), “a clinical business entrepreneur, charged with developing the school’s practice portfolio” (ibid. p.67). The ANPD is responsible for overseeing contractual arrangements, business and clinical outcomes, mentoring the staff, and promoting a culture that supports evidence-based clinical practice (Rudy et al. 1995). It sometimes also includes responsibility for creating new sites for clinical placement, coordinating clinical experiences with other schools and agencies, solving problems relating to students’ clinical placements, and ensuring compliance with standards and requirements relating to clinical practice, including legal and contractual obligations (Gregg & Williams 2001). In all these matters, the ANPD must advocate for and protect the interests of the school, its staff and students. The precise role and location of the ANPD will differ according to the needs, organizational structure and resources of the school, but have been comprehensively outlined by Sebastian, Mosley and Bleich (2004).

A number of U.S. universities have extended their adjunct appointments to senior levels. In early 2005, for example, the University of Washington School of Nursing appointed the Chief Nursing Officer of the Harborview Medical Center as an *Assistant Dean for Clinical Nursing Practice* (University of Washington School of Nursing 2005, p.16).

In the U.K. and Australia, *Clinical Professors* are an important form of JA and a potential exemplar and locus of FP. While the nursing policy documents and reports of the U.K. Department of Health do not refer to “Clinical Chairs” or “Clinical Professors” (e.g. Department of Health 1999a, 1999b), Australian universities have, or have had, professorial joint appointees in many disciplines, including nursing, dentistry, medicine, psychiatry, psychology, and veterinary science, and more recently in accountancy, business and commercial studies, engineering, architecture, law, chemistry and marine sciences. For example:

- The University of Sydney has not only had Clinical Professors appointed in most health related disciplines, but also three jointly funded Chairs in Law, dedicated to feminist issues, dispute resolution, and industrial relations respectively.
- The University of Wollongong has, or has had, a jointly funded Professor of Environmental Science, and Professors of Law, entailing both academic and ‘clinical, or ‘practice’, commitments.

The role has appeared in the U.S., largely as a response to the call made by the Holmes Group (1995) for the creation of “clinical professorships” operating between local schools and university schools of education.¹⁹ Appointees were seen as coming from among the

ranks of expert teachers rather than from among the academics, and would “form a living bridge between campus and practice” and while they would have “their tenure with the schools [they would] collaborate with faculty tenured with the university [in] making significant contributions to programs of teaching and inquiry” (Bullough et al. 2004, p.506).

¹⁹ It is important to recall that in America the term ‘professor’ is used much more freely than elsewhere, and that American publications discussing the clinical role of professors often have little direct bearing on the concept being reviewed here.

In nursing, these positions are funded jointly by the health service and the university or, occasionally, exclusively by the health service; the appointee may be based primarily in the clinical setting or the university, or may divide their time between each. They are promoted as providing opportunities for bridging the gap between the academic and service systems (Dunne & Yates 2000).

5.3 Current Status of Joint Appointments in Australia

JAs, including conjoint appointments, adjunct appointments, and clinical chairs, are widely in place across Australia. Most universities have formal protocols, detailing the arrangements which pertain between themselves and clinical agencies in respect of JAs. In some cases, the need for such appointments is the subject of general policy statements issued by State health agencies, which may lead to policy statements developed collaboratively with specific universities, addressing issues such as funding, location, and responsibilities. Under the rubric of ‘conjoint appointments’, the policy subscribed by the University of Tasmania and ²⁰ the Tasmanian Department of Health and Human Services, for example, describes roles for the clinician with academic responsibilities and vice-versa. It provides a substantial list of benefits to the state, the university and the post holder, including the rather enigmatic claim that the candidate can progress their career in both clinical service areas and academic areas simultaneously.

In Australia, the UK’s ‘Clinical Teacher’, may also be called the *Clinical Nurse Teacher* (Howie 1988; Sellick & Katinsaki 1992) or the *Clinical Educator*, and is likewise not a joint appointee, but employed by the health service/hospital to teach and supervise students’ clinical skills in the client care setting (Ferguson 1993; Wellard, Rolls & Ferguson 1995).

Another common cross-over role in Australia is the adjunct appointment, notably the *Adjunct Lecturer*, who – like the Clinical Faculty noted earlier – is an expert clinician who provides clinical instruction and other educational activities, in the university and in the clinical setting, in addition to their usual direct patient care roles. The adjunct appointee enjoys the privileges of membership of the School and the University, but is not remunerated by the School and remains in the employ of the health service. In some institutions they are described as *Clinical Associates*. Alongside these is an army of ‘casual’ *clinical teachers*, who are brought into the School on an ‘as needed’ basis to teach, support and assess, in relation to clinical topics in which they are expert practitioners. These staff represent perhaps the most significant interface between the academic and clinical areas in the context of undergraduate nurse education.

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first signed in 2000, and now in a 2004 revised version

Almost every Australian nursing school appears, at the time of writing, to employ a wide range of these adjunct and cross-over appointees, under a variety of conditions.²¹ Most provide support to students and/or teach clinical subjects in the university, some are specialists in particular clinical subjects, and a few have a specific research role. Some universities have extremely large numbers of such appointees²², whilst a just a few have none at all. JAs, on the other hand, are not only widespread in Australia but they may also work in almost any clinical area, including forensic mental health (Martin 2002; McKenna 2002; Musker 2002), drug and alcohol services, and palliative care, and may be appointed at any level from lecturer to professor. The following selection of examples illustrates the range and nature of JAs:

- The University of Melbourne, for example, employs a Senior Lecturer who is also a Psychiatric Nurse Education Consultant and is based in a local hospital setting, and an Associate Professor who is also a Senior Nurse in the Victorian Institute of Forensic Mental Health.
- The University of Adelaide has a JA shared with the Rural Health School in Port Pirie.
- Edith Cowan University has a range of JAs including Associate Professors in Critical Care and Paediatric Healthcare and also *Practitioner Scholars* in mental health and surgical/medical settings.
- The Flinders University has two JAs, one with local hospital and another with drug and alcohol services.

Clinical Chairs or Clinical Professors are especially common in Australian nursing, and are generally endorsed by the major stakeholders, such as State Health Departments and the Royal College of Nursing Australia. Indeed, appointments at professorial level in the last few years are perhaps as likely to have been clinical appointments as not. Some 5 years ago, the New South Wales Health Department counted at least 24 joint appointments in nursing in that State, at Associate Professor or Professorial level, and planned for this figure to double in the following few years. Clinical Chairs are typically funded jointly by the university and the industry partner, but a few are funded wholly by the latter. A rough estimate is that there are currently some 25-30 joint appointments at professorial level in Australia.

Chapter 5 of the Report of the Senate Inquiry into Nursing, *The Patient Profession: Time for Action* (Commission of Inquiry 2004) made “a number of recommendations to improve the interface between the education sector and health system including partnership initiatives and arrangements, joint curriculum development, and joint appointments” (Senate 2002, p.xiv). Recommendation 47 suggests that “The Commonwealth provide funding for the establishment of more joint appointments between universities and health services.”, whilst Recommendation 48 calls for “funding for the establishment of additional clinical chairs in nursing”.²³

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I am grateful to the Heads of Schools for volunteering information about the JAs currently in their employ.

e.g. the School of Nursing at the University of Adelaide currently has c.250.

These recommendations, it must be said, proceed from an extensive consultation process and reflect the views of influential nurses and nursing organisations across Australia, rather than from a detached assessment of evidence regarding their proven value. Furthermore, the section of the Report dealing with Clinical Chairs cites submissions made by only one university, and it might be tempting to assume that this indicates that they no longer attract widespread support. Reasons why this might be the case are discussed briefly below, in Sec.5.5.

Certainly, in recent years, tighter fiscal controls and increased concern over the ability to meet basic teaching and other on-site commitments has led to a tailing off of such appointments. In some parts of Australia, Clinical Chairs/Professorships are not being continued, with appointees not being offered renewal of contracts, and the positions not being advertised, whilst elsewhere a few new positions are still being created.

5.4 Benefits of Joint Appointments and Lecturer-practitioner Roles

Many authors have hypothesized substantial benefits accruing from the development of joint appointment roles, covering clinical practice, education, research and management.

Early claims as to the benefits of JAs, reported by Ogilvie et al. (2004), are as follows:

- familiarity with clinical environments enhances teaching performance (Andruski et al. 1997; Rundio & Warner 1992);
- faculty influence on nursing practice increases (Andruski et al. 1997; Mason & Jinks 1994);
- working with students is both personally and professionally challenging and provides a venue for increasing teaching skills (Andruski et al. 1997; Arpin 1981; Lachat et al. 1992; Minarik 1990; Pierik 1973; Wyness & Starzomski 1989);
- opportunities to publish, present at conferences, and engage in research are more available (Andruski et al. 1997; Minarik 1990; Wyness & Starzomski 1989);
- faculty self-confidence, nursing skills, and professional credibility are enhanced (Kuhn 1982; Fawcett & McQueen 1994; Gresham 1983; Minarik 1990; Patton & Cook 1994; Rasmussen 1984; Royle & Crooks 1985);
- enhanced cross-institutional cooperation and communication (Acorn 1990; Andruski et al. 1997; Mason & Jinks 1994; Wyness & Starzomski 1989);
- increased practice-based research studies (Acorn 1990; Lachat et al. 1989);

Mezey et al. 1988);

- increased personal and professional prestige (Mezey et al. 1989);
- access to highly qualified faculty with recognized clinical expertise at minimal or no additional cost (Andruski et al. 1997; Wyness & Starzomski 1989);
- integration of theory and practice in the nursing program (Andruski et al. 1997; Gresham 1983);
- fewer difficulties arranging clinical experiences for students (Andruski et al. 1997);
- increased clinical expertise available for student teaching and course development and implementation (Andruski et al. 1997);
- students experience the advantage of instructors familiar with the operations of clinical units (Andruski et al. 1997; Emden 1986; O'Neill 1985; Rundio & Warner 1992);
- perceptions of being more welcome on those units (Andruski et al. 1997; Kruger 1985);
- students receive more current information (Andruski et al. 1997; Wyness & Starzomski 1989);
- students have a role model to look up to in the clinical setting (Minarik 1990);
- an enhanced learning environment (Acorn 1990);
- teachers able to integrate lecture material into everyday practice (Fawcett & McQueen 1994);
- easy “on-site” access to faculty (Andruski et al. 1997);
- clinical agencies might experience enhanced ability to recruit new graduates since students have more satisfying clinical experiences (Andruski et al. 1997; Rundio & Warner 1992; Salvage 1983);
- closer relationships with nursing education institutions might increase opportunities for cost recovery (Wyness & Starzomski 1989);
- potential for greater clinical or theoretical knowledge of practicing nurses (Andruski et al. 1997; Lachat et al. 1992; Pierik 1973);
- enhanced patient care (Acorn 1990; Arpin 1981; Davis & Tomney 1982); and,

- increased sense of agency support among nurses (Rasmussen 1984).

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The Commonwealth Government response simply reaffirms that these appointments are made at the discretion of the universities and the States, and that no special funding would be made available by the Commonwealth (Senate Community Affairs Reference Committee 2005)
Beitz and Heinzer (2000) tabulate similar benefits alongside a range of challenges.

Academic staff also report an increase in self-confidence, and a more realistic teaching approach, (e.g. Arpin 1981; Davis & Tomney 1982). In the University of Alberta study (Andruski et al. 1997), much cited above, “students commented on the value of concrete real examples provided in seminars, closer relationships between instructors and staff nurses, and increased opportunities to change clinical assignments when an original assignment offered inadequate learning experiences” (Ogilvie et al. 2004, p.113).

These claims must be carefully assessed, however, and in most cases are found to be based on authors’ impressions rather than carefully conducted research. When research is being reported, the methods tend to subsume possibilities for bias, usually in the direction of suggesting more positive benefits than is actually the case. Comparative claims, expressed in terms of “greater”, “better”, “more”, or “enhanced”, for example, are of no value because the baseline to which the comparison is being made is not specified. Furthermore, there is little to be gained from studies which compare perceptions of a past situation in which there were no JAs, with a present situation which does include JAs.

In the United Kingdom, research into JAs has been mostly small scale and interpretive, and has been focussed on the LP (Dearmun 1993, 2000; Fairbrother & Ford 1998; Fairbrother & Mathers 2004; Fitzgerald 1989; Lathlean 1992, 1995, 1997; Vaughan 1988, 1989). Elcock noted that commonly cited benefits include:

- positive consequences for patient care (Burke 1993; Fitzgerald 1994; Gould & Crooks 1996; Lathlean 1992; Stitt 1995);
- enhanced clinical credibility for the appointee (Dearmun 1993; Gould & Crooks 1996; Jones 1996); and,
- strengthened links between education and service (Davis 1989; Gould & Crooks 1996; Stitt 1995).

However, these and subsequent claims rest almost entirely on professional opinion and anecdote. Ioannides (1999), for example, argued on the basis of personal experience that LPs are in a good position to update their knowledge, positively influence standards of care and demonstrate credibility. Salvoni (2001), likewise based on personal experience as a JA/LP, found that students undertaking clinical practice in faculty health services reported better learning outcomes than when undertaking placements with academic staff not engaged in faculty practice. Drawing upon their own experience in a specific setting, Fitzgerald (1994)

described the role of the LP in introducing primary nursing to a hospital ward, while Hope (2000) suggested that LPs could significantly contribute to the implementation of the NHS clinical governance agenda.

Despite all these claims, it is difficult to find any rigorous research conducted on the benefits of LPs. As recently as 2004, Williamson, Webb and Abelson-Mitchell (2004, p.154) found that only the study by Driver and Campbell (2000) had demonstrated statistically significant benefits of LPs to students.

An English National Board study of nurse teachers and lecturers (N= 247), conducted by Day, Fraser, Mallik, et al. (1998), cast some doubt on the need for 'hands on' clinical practice as a vehicle for retaining and exhibiting 'clinical credibility'. It concluded that "Clinical credibility can be retained through a variety of ways which did not necessarily include regular 'hands on' practice, but did require up-to-date knowledge of practice. While the small sample of LPs in the study by Nelson and McSherry (2002) reported increased credibility because of their engagement in clinical practice, it is not clear whether this was a result of their general involvement and engagement with the practice setting or whether direct hands on care was an essential component.

The small but important qualitative study of nurse lecturers by Fisher (2005) illustrates that the notion of 'clinical credibility' is highly problematic. Fisher found that despite claims that clinical practice is essential to educators (Aston et al. 2000; Goorapah 1997; Perry 1999), the "participants rejected the view without exception that credibility could only be achieved by demonstrating competence in a clinical skill" (Fisher 2005, p.24), and notes that controversial views on this issue are apparent in the literature (Baillie 1994; Crotty 1993; Eraut 1994; Welsh National Board 1998). The participants in Fisher's study all rejected 'hands on' clinical practice as essential to their role, and rejected the salience of the conventional concept of 'clinical credibility', preferring 'currency' and 'awareness'. This is consistent with the findings of Day, Fraser, Mallik et al. (1998), and Fisher concludes that "Clinical currency would seem a much more meaningful expression as it captures the essence of contemporary nursing practice" (2005, p.28). It is also consistent with another recent qualitative study, which found that while senior clinicians strongly approved of LPs being present in the clinical setting and keeping in touch with practice, their credibility was reported by clinicians to be based on their experience and the knowledge base generated through that experience, rather than through continued direct 'hands on' care (Leigh, Howarth & Devitt 2005, p.263).

These limitations in the research on JAs and LPs are important to bear in mind when faced with the enthusiastic and repeated policy directives of the U.K. Department of Health (1999a, 1999b), which simply assume positive benefits to all concerned, but most notably to students, who will "acquire better practical skills" (1999a, p.27) as a result of staff having both clinical and educational responsibilities. There has been no systematic review of evidence concerning the value of JAs or LPs, and the policy statements cite little – if any – published research.

The benefits of Clinical Chairs or Clinical Professors as distinct from exclusively university-based equivalents are also not easy to specify. It might reasonably be expected that they will

be better placed to:

- access external and internal research grants;
- contribute to the strategic development of research in the health sector; and,
- facilitate relationships across the intersectoral divide.

However, a systematic literature search found no empirical evidence to support these suggestions. An evaluation of the role of impact of Clinical Chairs in Nursing and Midwifery is presently being conducted by staff at the Graduate School of Nursing at the Victoria University of Wellington, New Zealand (Nursing Research and Development Unit 2005, p.21).

5.5 Drawbacks and Problems Relating to Joint Appointments and Lecturer-practitioner Roles

Acorn (1991) surveyed 113 academic staff in Canadian universities, of whom 33 were joint appointees. She concluded that the joint appointees did not differ from traditional faculty in levels of role conflict and role ambiguity, scholarly productivity levels, or job satisfaction (Acorn 1991, p.225). However, drawing on Ogilvie et al. (2004, p.114), the criticisms of JAs may be summarized as follows:

- role ambiguity and/or conflict (Acorn 1991; Andruski et al. 1997; Emden 1986; Champion 1992; Gresham 1983; Patton & Cook 1994; Royle & Crooks 1985; Rundio & Warner 1992; Salvoni, 2000);
- differing role expectations between employers (Acorn 1988; Andruski et al. 1997; Champion 1992; Fairbrother & Mathers 2004; Minarik 1990; Patton & Cook 1994; Royle & Crooks 1985), leading to cognitive dissonance (Donnelly et al. 1994);
- dual accountability (Andruski et al. 1997; Fairbrother & Mathers 2004; Salvoni 2000);
- time constraints/workload (Acorn 1988, 1990; Andruski et al. 1997; Champion 1992; Hoffart 1989; Joel 1985; Kuhn 1982; Lachat et al. 1992; Mezey et al. 1988; Minarik 1990; Patton & Cook 1994; Rasmussen 1984; Royle & Crooks 1985; Salvoni 2000; Wyness & Starzomski 1989);
- lack of peer support (Rasmussen 1984; Royle & Crooks 1985);
- funding problems (Andruski et al. 1997; Dunn & Yates 2000; Rasmussen 1984; Royle & Crooks 1985);
- staff lack of understanding of joint appointment roles and responsibilities (Dunn & Yates 2000; Kuhn 1982); and,

- differing philosophies about student nurse education in partnering agencies (Kuhn 1982).

These findings are consistent with the candid observations of Sue Crane, the first joint appointee at Deakin University, who noted the role strain that working across two systems generated (Crane 1989). As with the reported benefits of JAs, these are mostly impressionistic and based on staff reports rather than careful research. As, Ogilvie et al. (2004, p.115) concluded, “the lack of research about joint appointments is surprising given the amount written on the topic”.

Similar problems associated with the LP role are also well documented (Day, Fraser, Mallik et al. 1998; Gibbon & Kendrick 1996; Hollingworth 1997; Leigh et al. 2002; Woodrow 1994a, 1994b), the core features being:

- lack of career structure;
- work overload; and,
- divided loyalties.

Rhead and Strange (1996) acknowledged that the unacceptable aspects of their work as LPs are role conflict and stress, exacerbated by the lack of managerial and organizational support. Hollingworth (1997), Lathlean (1997) and Fairbrother and Ford (1997) all independently identified role overload, dual accountability and authority as the key problems for LPs. Role ambiguities have been noted by many commentators (Day, Fraser, Mallik et al. 1998; Gibbon & Kendrick 1996; Leigh, Monk, Rutherford, et al. 2002; Woodrow 1994b). The large scale survey by Day, Fraser, Mallik et al. (1998) also stressed the lack of organisational management and planning around lecturers’ practice commitments. Leigh, Howarth and Devitt (2005) report continuing lack of consensus over role and responsibilities, and note that previous studies tend to reflect local models and approaches.

Lathlean’s (1997) book is a report of an ethnographic study of the working lives of five English LPs, conducted during 1990-91, together with results of a brief survey (N=58). Some 60% of those LPs surveyed regarded the role as workable only under certain conditions, and another 2% regarded it as not workable at all. The biggest single problem was workload, and strict prioritization of tasks and regularly working beyond the contracted hours were essential coping strategies, along with the ability to refuse work, and to manage time effectively.

Lack of consensus is also problematic in relation to the impact of the LP on clinical development. Wright (2001, p.198) warned that “progress is dependent on all those involved, sharing common goals in the implementation of evidence based health care as it will continue to remain high on the agenda in the educational and service sectors”. As noted previously, Wright came to the view that, in the absence of consensus and in the face of the attitudinal and practical hurdles facing LPs in the clinical setting, LPs could only have a significant impact on practice if they were senior appointments in the clinical hierarchy.

LPs not only have their critics, but also direct opponents. One early commentator (Osborne 1991) pointed out that academic staff do not need to practise (*sic*) in clinical areas since competent practitioners are already available to mentor students. More dramatically, Calpin-Davies (2001) cast serious doubt on the tenability of the whole concept, noting that its popularity is driven by political imperatives rather than educational ones, and drawing attention to the direction that this is taking nursing educators in the United Kingdom. “The latest demand, fortunately superbly rebutted”, she says, “by Rafferty (1999), is that they be evicted from universities back to academic and intellectual isolation and more importantly, firmly under the control of the health service managers” (ibid., p.281). Calpin-Davies continues “...some nurse educators and their leaders have accepted this perspective unquestioningly. Indeed they seemed to have perpetuated, pedalled and thrived on this guilt-inducing myth. The result has been to devalue the function of nurse educators, replacing them with the service-controlled, ubiquitous lecturer practitioner...” (ibid., pp.281-282). The author then launches into a case for abandoning the LP role altogether.

Calpin-Davies (ibid., p.282) points out that according to some commentators “instead of reducing the theory-practice gap clinical teachers actually served to compound the problem (Marriott 1991, Akinsanya 1993)” and she sees no reason to believe that LPs will be any more successful in this regard. It may be added that Registered Clinical Nurse Teachers (RCNTs) were also found to suffer from a lack of clarity over their duties (Norcliffe 1993; Owen 1993), a perceived and actual low status in relation to the Registered Nurse Tutors (Mallik 1993), and an attitude among colleagues that it was an ‘easy option’ (Norcliffe 1993). Furthermore, their academic credibility was often in dispute, rather than their clinical ability, especially given the lower status accorded clinical practice in the context of the academy (Baillie 1994; Wong & Wong 1987). Courses leading to registration as an RCNT stopped in 1985 (Fairbrother & Ford 1998, p.275). Similar problems have been noted in relation to the LP, and a systematic review of research into LP roles led Williamson (2004, p.793) to conclude that bridging the theory-practice gap was “not a pressing issue for most LPs”.

Although a detailed consideration of the so-called *theory-practice gap* lies outside the scope of this report, it is important to note, with Calpin-Davies, that not everyone believes that it should be closed. Cook (1991), for example, suggests that closing the gap may actually hinder practice development by stifling innovation and change. Others argue that it might, conversely, hold up theoretical development, which is often ahead of the practice world since it is unconstrained by economic, political and organizational handicaps. Some have argued that the gap can be productive and drive education and research (e.g. Rafferty, Allcock & Lathlean 1997), while others argue that such a gap does not exist (e.g. Allmark 1995). From a critical theory perspective, theory is inherent in and inevitably underlies practice, whilst practice should inform all theories, and it is the extent to which this reflexive relationship is made explicit which is at issue, rather than any ‘gap’. It is out of a concern for making explicit the theories that are inherent in practice that the notion of the reflective practitioner has grown, and has become a key element in defining the role of the nurse. In some respects, therefore, the championship of the reflective practitioner model in nursing is at odds with that of perceiving and attempting to bridge a theory-practice gap. Australian authors have made a particularly strong contribution to the literature teasing out these issues, and some key

contributions are described by Usher and Holmes (2005).

Calpin-Davies (ibid.) draws attention to the anomaly that the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC 1994) required that clinicians undertake a mere five days theoretical education every three years to maintain their theoretical credibility, whereas nurse educators are repeatedly castigated for having little contact with practice and therefore little clinical credibility.

In conclusion, Calpin-Davies (ibid., p.282) dismisses the LP role as untenable because of the high level and diverse nature of expectations. “It is self-evident”, she writes, “that this superhuman performance, should it be remotely achievable, is unsustainable.” LPs are “the ‘victims’ of straddling two organizational domains”. She also argues that the popularity of clinical educators is related to the fact that clinical staff, like all joint appointees, are cheaper to employ than educators. Furthermore, since they are only educators for part of their time, they also represent – as do many other joint appointment configurations – the casualization of nurse education.²⁴ Unfortunately, “in the current [United Kingdom] climate of a market-led approach to educational purchasing, the lecturer practitioner post is often the sole access route to a permanent education post” (ibid., p.282). As nurse educators located in universities desperately attempt to satisfy academic expectations embracing teaching, research and scholarship, as well as contributing to their discipline, their profession, the university and the community, and as joint appointment and various cross-over and specialist roles proliferate, Calpin-Davies warns of “the potential for making nurse education the next NHS skills mix debacle (Glen & Clark 1999)”²⁵ (ibid., p.283).

Intriguingly, her own preferred approach to conceptualizing the role of the nurse educator (Calpin Davies 1996, 2001) is in terms of an adaption of the primary nursing model, first actioned in the clinical setting in the United Kingdom by Alan Pearson and his colleagues in Oxford and a crucial contextual factor in Vaughan’s original concept of the LP.

Many commentators report that lack of career structure is a problem for LPs. The literature indicates that LPs are located almost exclusively in the clinical area and that they do not participate significantly in university life. It is hard to see, therefore, how the role can be fulfilled without compromising *academic career prospects*, since there is normally a requirement that academic staff contribute to the academic and administrative work of the university. This problem is compounded by the almost complete absence of any reference to LPs’ involvement in, let alone initiation of, research, or reference to conventional research outputs such as refereed publications. Participation in research and in university life are core expectations of academics, incorporated into promotion criteria, but these are clearly problematic for the LP. Although a few British health trusts have created new positions, notably *Associate Clinical Deans* (Leigh et al 1999, p.212), which may offer a step forward, it is also reasonable to question the value of the LP role in relation to *clinical career prospects*, since it does not generally involve sustained clinical practice, clinical development or research, or significant service management or administration functions.

²⁴ It is worth recalling the proliferation of adjunct, part-time, casual and honorary staff associated with schools of nursing in Australia.

²⁵ The history and current status of the skills-mix debate is detailed in the OECD report by Buchan and

Calman (2004)

While the research suggests that LPs are generally enthusiastic about their role, the demands it creates and the drawbacks it entails suggest that appointments should perhaps be short-term. A recent qualitative study of the experiences of LPs by Leigh, Howarth and Devitt (2005, p.264), suggests that the lack of career structure continues to be a problem, and is exacerbated by role ambiguity, which persists despite having long been noted in the literature. “Without strategic direction”, they suggest, “lecturer practitioners posts will only ever have a short life span” (ibid., p.265). Indeed, noting the emphasis now being placed on the *Practice Educator* role, located exclusively in the practice setting, the authors conclude that “It could be considered that the lecturer practitioner is perhaps a role which is past its sell-by date as nowhere in the ENB guidance (ENB/DOH, 2001) is the lecturer practitioner role identified. Indeed the Royal College of Nursing’s practice placement guidance gives the role only cursory attention (RCN, 2002)” (Leigh, Howarth & Devitt 2005, p.264).

In respect of Clinical Chairs and Clinical Professors, the absence of published accounts or research make it impossible to report with any reliability in relation to the provision of adequate support, or the general level of success they have enjoyed. The current level of success associated with the positions has not been the subject of published research.²⁶

6. Establishing and Managing Faculty Practice

Saxe, Burgel, Collins-Bride, et al. (2004) outline the challenges that face schools seeking to rationally and systematically develop faculty health services. “Lessons learned” they write, “include the following:

²⁶ Anecdotal reports and personal experiences of Clinical Chairs and Professorships in the Australian context suggest a history of mismanagement, misunderstanding and lost opportunities, leavened by occasional successes, innovations and high productivity. They appear to have been especially problematic in mental health settings, where lack of resources and under-developed services exacerbate lack of clarity as to the role.

Coalition building among multiple stakeholders is a challenging process that requires a great deal of time and commitment in the face of competing priorities. Part of this commitment involves a constant willingness to revisit and restate the core values that brought the stakeholders to the table in the first place. It is critical to keep the vision at the forefront during the lengthy process of laying out a strategic direction for faculty practice.

It is important to recognize that success does not always materialize on the first try and that sometimes it is necessary to re-trace one’s steps in order to achieve the desired goal. One example is the computer-based cost/revenue monitoring system that had been initially developed for the Department’s faculty practice sites. A system was designed in collaboration with faculty, and all agreed that it made intuitive sense and contained all the necessary elements. However, during the pilot test, it became apparent that the system was too unwieldy for faculty to use and it was subsequently redesigned. Persistence and a willingness to try again in the face of obstacles are the keys to overcoming these types of challenges.

An on-going commitment to the strategic planning process is critical for successful programs. Assessment of progress being made toward the identified goals will help to create the steps needed for improvement.

The development and implementation of a strategic plan requires strong leadership and coordination in order to ensure that momentum is maintained for all aspects of the plan. In a University culture in which individual achievement and autonomy are valued and rewarded, ensuring that the organization is moving forward strategically as a whole is a challenging endeavor that requires consistent leadership and monitoring. Plans are underway at the School of Nursing to systematically address strategic planning, regulatory compliance and quality initiatives on a school-wide basis for all faculty practices with the support from the Dean and selected faculty members from each Department.

It is critical to be realistic in choosing the goals and objectives for faculty practice. Competing priorities can result in delayed or non-implementation of a plan if it is too ambitious or is perceived as unachievable. When outlining activities, timeline, and persons responsible for each objective, realistic estimates of time and resources available are important factors to consider.

Finally, one of the important aspects of a strong strategic plan is its flexibility. When changes in the environment occur, shifts in the direction of a program and its activities are often necessary. For example, one of the goals of the strategic plan was to form a Community Advisory Board to discuss faculty practice research. However, this discussion may be premature in still-developing relationships with community partners. Therefore, other ways of building stronger ties with community partners may be warranted.

(Saxe, Burgel, Collins-Bride, et al. 2004, pp.187-188)

Dracup (2004, p.176, italics added) offered the following warning to schools whose staff wish to undertake clinical practice:

Clinical practice can exact a toll on faculty as they struggle with the priorities of teaching, research, and practice. Burnout from multiple roles is a constant threat and can become all too real if the clinical practices are undervalued in terms of their contribution to the school and the university. *Faculty structures should be continually assessed to ensure appropriate compensation and advancement for faculty who engage in faculty practices. Faculty must see the connection between their efforts in a school-sponsored clinical practice and their own professional advancement.* The messages in this regard must be clear and consistent from academic administration and be reflected in promotion criteria.

This is well-founded in view of the strong empirical evidence confirming that, regardless of the context, workload and role confusion are important problems for academics who engage in clinical practice.

Dracup goes on to offer advice to schools considering the creation of faculty health services, and this is summarized below in **Table 2**

An important issue not included in Dracup's criteria is that of quality assurance. As noted earlier, it is crucial that faculty health services aim to be exemplars of the highest standards of care and that they can demonstrate their effectiveness. It is recommended that strategies for pursuing these aims be built into the agreements, policies and procedures at the planning stage.

Table 2: Strategies to enhance financial viability of nursing faculty practices (Dracup 2004, p.177)

- Identify market needs and create an initial business plan
- Market clinical services to increase diversity of payer mix
- Improve billing and coding practices through consultants or grants
- Create a lay Board of Advisors to spearhead philanthropy
- Establish contracts with payers or community institutions for services
- Secure external funding from foundations and federal/state government through grants
- Create presence in community through active involvement of media

Quality indicators for faculty health services have been devised by McNiel, Mackey & Sherwood (2004) as a component of their “Customer-oriented Faculty Practice Model”, and are summarized below in **Table 3**

Table 3: Quality indicators for academic nursing centers (McNiel, Mackey & Sherwood 2004, p.192)

Patients and Contract Holders

Health education and wellness services
Multiple patient care processes
Satisfaction feedback systems

Faculty/Staff/Students

Credentialing and continuing education efforts
Orientation, evaluation and satisfaction processes
Educational opportunities for students

Finances

Financial stability

Marketing plans
Billing and insurance systems

Administration and Governance

Quality assurance program
Policies and procedures
Clinical records and information systems

Facilities

Comfortable, safe, and convenient environment for patients

Research

Active research efforts by faculty and students

Whether it occurs in the context of a faculty health service or the Australian FP concept, it is also crucial that FP is conducted in a way that not only pursues high standards of care but which ensures that academic staff are capable and competent clinicians. Daly (2004) has drawn attention to the need for a system which will ensure competency and evaluate the performance of academic staff engaged in FP.

A workable system of FP also needs to have in place procedures that ensure that clinical practice is taken into account for the purposes of performance review and career development. In order to achieve this, the ways in which FP contributes to the scholarly record of staff and to their prospects of tenure and promotion should be made explicit.

A detailed survey and report on the relationship between FP, tenure and promotion was provided by the NONPF (2000), taking as its starting point Taylor's (1997, p.3) declaration that "Practice contributes to scholarship and could or should promote the goals of academia and advancement within the academic system...challenges to the future of faculty practice will include integrating practice into traditional academic missions of teaching and research". The also report articulates Boyer's model, and draws on the American Association of Colleges of Nursing (AACN) *Position Statement on Defining Scholarship for the Discipline of Nursing* (AACN 1999).

Boyer's (1990) model of scholarship was subsequently discussed in relation to clinical practice (Boyer 1995; Starck 1996), and developed by Glassick and his colleagues (Glassick 1999, 2000; Glassick, Huber & Maeroff 1997) into a set of criteria for evaluating scholarly activity. The NONPF (2000) report suggests that these can be appropriately and constructively applied to FP, and are as follows:

- *Clear goals.* The practitioner will state the overall goal of improving the health status of an individual/community, and then add additional goal as needed for the appropriate practice setting.
- *Adequate preparation.* The individual practitioner will demonstrate that s/he has attained the necessary education and experience to provide expert care in the practice setting. Clinical excellence requires both maintaining national certification and continuing growth and experience through practice and continuing education.
- *Appropriate methods.* The practitioner will incorporate evidence-based methods and innovative delivery system components into practice as evidenced by current standards, protocols and research.
- *Significant results.* The practitioner will monitor the effectiveness of one's advanced practice nursing interventions through a variety of quantitative and qualitative methods.
- *Effective communication.* The practitioner will share methods of care delivery, interventions, and unique experiences through broad methods of dissemination including presentations, publications in professional and consumer literature, and enhanced teaching.
- *Reflective critique.* The practitioner will continuously attempt to improve practice expertise by ongoing self and peer evaluation, and by identifying areas for further research.

AACN (1999) has likewise provided excellent examples of the definition of the scholarship of clinical practice, including:

- clear goals;
- Peer reviewed publications of research, case studies, outcome/evaluation projects
- Funded research (level of funding would be determined by the research level of the institution)
- Presentations/posters based on research and/or practice at national and international meetings
- Presentations/posters informing policy from practice and research
- Requests for consultation

- Peer review of practice consistent with evidence based guidelines
- Develops and informs standards of practice based on research
- State, regional, national, international recognition as a master practitioner
- Non research grant awards in support of practice

Furthermore, the standards of scholarship described by Glassick (1999, 2000) can be used as a guide for evaluating FP. So, we may ask whether there are:

- clear goals;
- adequate preparation;
- appropriate evidence based practice methods and innovative processes of care;
- significant outcomes, including added value to the school’s mission;
- effective communication; and,
- reflective critique.

NONPF recommends these standards serve as a guide for both administrators and faculty members when establishing and maintaining FP, and in evaluating FP activities for the purposes of promotion and tenure.

Although quite different in character, Boyer’s work also forms the basis of the “guidelines for clinical scholarship” developed by Fiandt, Barr, Hill, et al. (2004), which seek to establish clear strategies specifically for ensuring that FP contributes to the scholarly objectives of the academy (**Table 4**, below). These strategies are effectively a set of criteria for judging the quality of work by academics located in faculty health services, and can easily be extrapolated to work in any clinical practice situation.

Table 4: Clinical Scholarship Guidelines (Fiandt, Barr, Hill, et al., 2004, p.150)

Quality

- Demonstrates expertise as clinician
- Applies established standards
- Creates and implements mechanism for quality improvement in practice
- Utilizes program evaluation to improve practice

Governance

Demonstrates ownership of practice (autonomy and accountability)
Practices independently and interdependently
Demonstrates financial competence related to the business of practice
Participates in management of practice
Works to increase financial resources through development of service grants
Participates in the development and implementation of the infrastructure to support the academic practice model within the College of Nursing

Leadership

Participates in national advanced practice standard development
Mentors clinicians to develop scholarly clinical practice
Mentors clinicians in developing their faculty practice role
Serves as consultant on advanced practice and clinical issues
Develops innovative advanced practice strategies
Develops and maintains community partnerships for interdisciplinary relationships
Participates in public relations/marketing for the advanced practice role and academic practice model

Knowledge development

Participates in research and development of conceptual models
Develops and tests research-based protocols for advanced practice
Develops and maintains collaborative initiatives for interdisciplinary research
Demonstrates a commitment to grant writing with an emphasis on client outcomes and program evaluation
Demonstrates and engages in outcome-based clinical practice with an emphasis on scientific rigor
Tests community-based models with application to practice
Publishes and makes presentations related to practice

It should be noted that while the authors say that these criteria were developed by a “Faculty Practice Committee” using brainstorming, they do not provide details of the procedure or the composition of the committee. It included experienced nursing academics, familiar with the literature, but it is not clear whether it included clinical, managerial or other experts, and nor whether other disciplines were represented. There is no evidence that the Committee conducted any kind of literature review or consulted the research evidence.

Responding to the research indicating recurring problems with academics undertaking clinical practice, Norbeck and Taylor (1999) identified the key problems which need to be overcome for successful FP.

1. Integration of faculty roles (clinician, educator, researcher)
2. Collaboration that is interdisciplinary for support networks, creativity, and increased funding opportunities
3. Organizational support for professional and policy oversight
4. A faculty practice plan to guide financial and workload considerations

The challenge presented by FP is nicely encapsulated in these four points: unless they can be effectively addressed, it is difficult to see how a system of FP could be sustained.

6.1 Concluding Note

In the Australian context, there are frequent expressions of concern among health employers and commentators about the clinical skills of new nursing graduates, often linked to accusations that university educators are out of touch with practice. In the universities, on the other hand, there is a sense that most clinicians are out of touch with many of the key developments and themes that characterize an enlightened approach to nursing. Clinicians are regarded as rarely consulting the refereed literature, largely unresponsive to calls for evidence-based practice, and as inept and largely inactive in relation to research.

Faculty practice offers a way in which these two polarized views might gradually be overcome, and replaced by a productive, mutually respectful relationship with benefits to academic and clinical staff, health and academic institutions, and individuals and the community. While this report has been presented in three sections, dealing with different conceptions of faculty practice, they represent a wide range of overlapping innovations which have in common the notion of partnership between academic and clinical agencies, embodied in a variety of initiatives in which nurses may assume meaningful roles in both clinical and academic settings.

The array of benefits of these various conceptions and innovations, along with their difficulties and drawbacks, have been reviewed here, at least as far as existing research allows. Some of them, such as faculty health services, require substantial investment of funds, time and effort, underwritten by determined institutional and political support of a kind that is unlikely to emerge at present in Australia. Other, less ambitious approaches such as joint appointments and other 'hybrid' roles are already well established and offer realistic avenues for further strengthening the academic-clinical relationship. 'Hands-on' clinical practice by nurse academics, as part of a formal arrangement, factored into workloads and recognised for purposes of institutional and individual performance review, has rarely been tried in Australia, and its development is unlikely in view of increasingly burdensome on-site academic workloads.

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