

**COUNCIL OF DEANS OF
NURSING AND MIDWIFERY
(Australia & New Zealand)**

Position Paper

Faculty Practice

As at 24 March 2006,

The CDNM notes that:

The language used in relation to faculty practice is sometimes confusing, and any discussion must establish in what sense terms are being used. It 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 specifically, however, in the United States faculty practice 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 (National League for Nursing 1989).

In the United States, the definition preferred by the National Organization of Nurse Practitioner Faculties (NONPF) (<http://www.nonpf.com/>) is commonly accepted, 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 description brings together the Australian, New Zealand and American concepts, and draws attention to the fact that faculty health services may serve as the primary location for faculty practice.

A number of models of faculty practice emerged during the 1990s (e.g. Barger & Kline 1993; Hutelmyer & Donnelly 1996; McNeil & Mackey 1995; Potash & Taylor 1993). 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* which corresponds more closely to New Zealand positions.

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.

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

- an opportunity to develop and test new approaches to care delivery;
- an opportunity to develop a range of management and leadership skills;
- a setting in which to conduct quality nursing research;
- provision of a safe and controlled clinical placement option for nursing and other students, where high quality learning may take place; and,
- 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.

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

- the negotiation of mutually acceptable contractual arrangements
- the disparate nature of the aims, objectives and motivations of the overseeing agency, the university and individual academic staff;
- the cost involved in resourcing the service; and,
- recognition of clinical practice as a legitimate element in the academic portfolio of university staff.

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

In summary:

- 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.
- Faculty health services provide closely monitored and expertly facilitated clinical placements for students.
- Faculty health services may make a significant contribution to the well-being of underserved populations in the community.
- 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.

- The creation of faculty health services requires substantial investment of time, energy and funds, involving a variety of stakeholders.
- Faculty health services should be the epitome of good practice and mechanism should be in place for evaluating clinical and academic outcomes.

Faculty practice in Australia and New Zealand dates back to the 1980s, with its introduction as a component of job descriptions for academic staff at the School of Nursing, Deakin University, Geelong, Victoria.

Academic staff may practice within various relationships, but practicing within a second, paid position “not contracted through a school of nursing” is “moonlighting” and not regarded as faculty practice (Anderson & Pierson 1983, p.132; Batey 1983; Dracup 2004; Polifroni & Schmalenberg 1985; Rodgers 1986). In a few Australian 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 not a formal arrangement involving the School, and is not monitored or evaluated, and despite the intentions of those concerned, does not constitute faculty practice. In New Zealand, some Universities allow up to 36 days approved private work which is monitored and may be used for clinical practice. In order to constitute faculty practice, 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.

Maintaining clinical credibility is often cited as a strong rationale for faculty practice but the notion of ‘clinical credibility’ is complex and may not be appropriate to the role of academic staff as perceived by clinicians. The research suggests that academic staff and clinicians tend to regard regular contact with the practice world as more important for academic staff than ‘hands-on’ clinical practice. The empirical evidence that lecturers regard clinical practice as a desirable addition to their role is equivocal.

If recent clinical practice were a requirement for continued registration, some form of faculty practice, 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. In New Zealand, the Nursing Council competency standards under Domain Two: Management of Nursing Care states that “Although nurses involved in management, education, research and policy making are exempt from being assessed against the above competencies in domain two, they are required to provide evidence of how they contribute to the management of care. (Nursing Council of New Zealand Competencies for the registered nurse scope of practice, June 2005)

Furthermore, faculty practice is difficult to incorporate into traditional notions of scholarship, and its contribution to the scholarly output of the institution or the academic profile of the individual is problematic. It has now all but disappeared in Australia, and this is widely attributed to cost implications, insurance problems and the burden of on-site academic workloads.

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, is either weak or non-existent.

It appears that, currently:

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

A number of problems appear to have contributed to this situation:

- the universities and schools 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 faculty practice, 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 faculty practice an expectation in Australia;
- individual nurse academics themselves, regardless of their opinion as to the value of faculty practice, 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;
- a host of questions arise regarding the administration and regulation of faculty practice (Daly 2003); in particular, there would need to be standards established in order to conduct fair and accurate performance appraisals of staff in respect of their faculty practice, 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, there is evidence that faculty practice 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;
- factoring faculty practice 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 faculty practice 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 faculty practice is not an employee of the clinical agency; and,
- staff have generally been unable to demonstrate unequivocal benefits from their faculty practice activities, and thus can not be justified in light of the costs involved and the competing demands.

The general lack of support in universities for faculty practice 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)."

If faculty practice is taken to refer to a situation in which an individual performs both academic and clinical roles, reference must be made to the range of 'cross-over' appointments that are now a common feature of nurse education. A vast range of job titles and work arrangements are in place, especially in the United States, representing every conceivable combination of teaching, research, administration and clinical practice. Joint appointments and innovative 'hybrid' appointments are significant expressions of collaboration between the academy and health services, and are common in Australia, and growing in number in New Zealand. They extend to professorial level and are usually associated with a specific nursing specialty or designated client group. Research consistently demonstrates that joint appointees are especially susceptible to role ambiguities, work overload and loss of career direction. It also suggests that many joint appointees, and academics engaged in faculty practice, undertake very little, if any, 'hands-on' clinical work, the focus tending to be on the support of students and the creation of a quality learning environment.

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 et al. (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 (ibid., p.282) dismisses the Lecturer-practitioner 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.” The popularity of clinical educators, she argues, 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. 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).

Although endorsed by most stakeholder organisations in Australia and New Zealand, there is little empirical evidence regarding the value of joint appointments, including clinical appointments at professorial level, and most published literature simply relates personal preferences and impressions. The dual role is reported to contribute little to either academic or clinical career prospects. Clear, mutually agreed responsibilities and goals are therefore essential.

The CDNM affirms:

There has been extensive research into the value and difficulties associated with faculty health services. Faculty health services constitute an important opportunity to demonstrate the commitment of the University, the School and the profession of nursing, to the well-being of the community, and can make a significant contribution to the health care of under-served individuals.

Faculty health services make a significant contribution to the range and quality of student clinical placements, and provide ideal opportunities for particular academic staff to engage in all aspects of faculty practice. They are an ideal site for developing a wide range of research programmes, including clinically focussed research, for trialling new working practices, and developing management and leadership skills.

The establishment of faculty health services is a complex task, but one which is familiar to stakeholders in the United States and extensively described in the literature.

There is insufficient evidence to confirm the far-ranging benefits claimed by many commentators for joint appointments and other roles operating at the interface between clinical and academic systems, although they have the potential to increase mutual understanding, and enhance the experience of students on in the clinical setting. Appointees are susceptible to work overload, role ambiguity and uncertain career prospects.

There is insufficient empirical research evidence to support a position on the value of faculty practice, to either the individual, the health service and the community, or the university.

There are substantial difficulties associated with developing faculty practice in Australia and New Zealand, associated with legal and contractual issues, cost considerations, staff workloads, competency and supervision, institutional objectives and conceptions of scholarship.

In the context of the modern university, nursing is a discipline which encompasses a wide variety of scholarly activities which may not require familiarity with, or experience of, clinical issues. Among these might be counted academics that 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 faculty practice 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.

The CDN M makes the following recommendations:

1. When considering adopting faculty practice, its value in assisting the School to meet university expectations for the School's academic performance should be established, and confirmed in a formal faculty practice policy.
2. Where faculty practice is adopted, it should be the subject of formal policy and the mission statements of the School. It should be the subject of formal agreements between all stakeholders, and all issues relating to costs and legal liabilities must be resolved in advance.
3. Faculty practice should generally be seen as optional, it should:
 - have unambiguous aims and projected outcomes;
 - be factored into staff workloads; and,
 - there should be formal mechanisms for ensuring safe and competent practice.
4. The value of faculty practice to the career prospects of the individual must be explicit, and it should be incorporated into personal performance review procedures approved by the university.
5. Schools considering introducing faculty practice should address potential problems in
 - integrating clinician, educator, and researcher roles for academic staff;
 - establishing interdisciplinary collaboration and support networks that enhance creativity and increase funding opportunities; and,

- overseeing professional practice and, developing and implementing relevant policies.
6. The trend toward a range of innovative roles which straddle academic and clinical systems should be encouraged. In view of the dangers of overload and role ambiguity, there should be clear objectives, precise indicators of performance, regular review, and support mechanisms specially developed for each appointee.
 7. Research should be conducted to evaluate all existing and projected forms of faculty practice and all roles which combine academic and clinical work.
 8. The development of faculty health services, as a preferred site for faculty practice, should be given consideration as a long term objective for Australian Schools of Nursing, and further discussed as a possibility within New Zealand.

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