CLINICAL PRACTICE: A DILEMMA FOR NURSE EDUCATORS

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Nurses on faculty are expected to demonstrate competence as practitioners, researchers and in the traditional role of educator. The dilemma faced by nurse educators in meeting the expectations of the universities and of the nursing profession is illustrated in Figure 1. Achievement of all aspects of the professional role is necessary in order for nursing faculty to attain and maintain collegial status with other health disciplines as well as credibility within the nursing profession. Practice can contribute to scholarship and, thus, provides a vehicle for achieving the goals of academia and promotion and tenure within the university system. Role fragmentation and work overload result when faculty attempt to address each function, separately, within the different social and bureaucratic structures of the university and the health care delivery system.

Goals of Faculty Practice

Faculty practice may be defined as the participation of nurse-faculty in activities related to client care. The goals of faculty practice are: to improve the quality of patient care and student learning; to promote professional development of nursing faculty and clinical staff; and to facilitate communication and co-operation between nursing service and education. Faculty practice provides a means of facilitating the development of clinical nursing research and the development and utilization of nursing knowledge. Fagin (1986) states that a further, often unstated goal of faculty practice is the empowerment of practising nurses and the nursing profession (p. 143). The level of power vested in nurses within the health care delivery system can be increased through clinical leadership and through demonstration of the full professional role of nursing.

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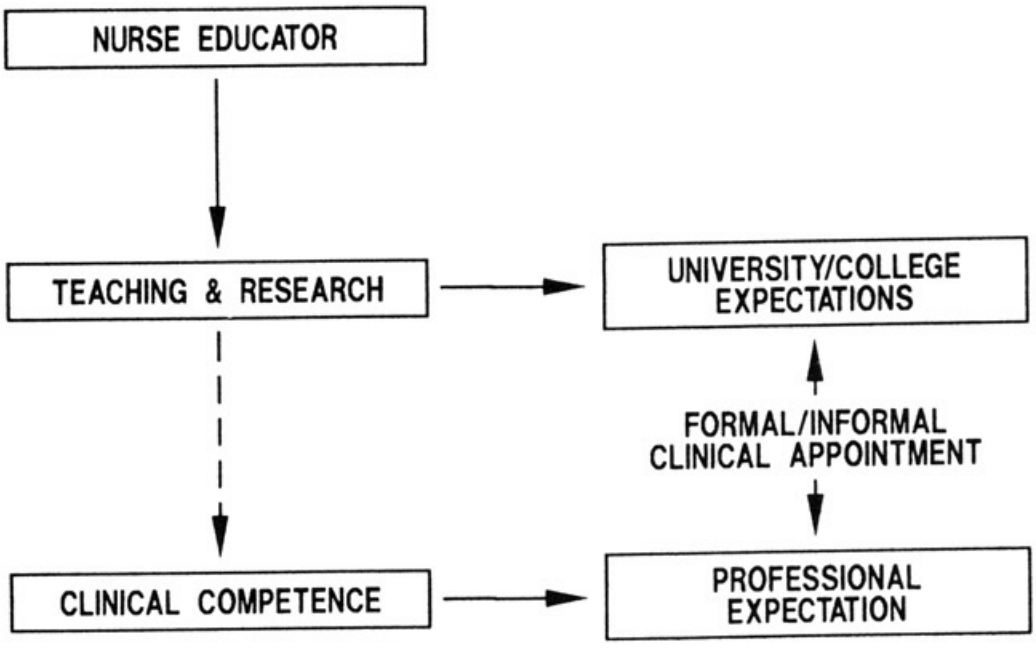

Figure 1: The Nurse Educators' Dilemma

Student learning is facilitated when clinical staff and students perceive faculty to be credible teachers and competent clinicians. Active participation of faculty in patient care and in decision making in the clinical setting improves communication between the university and the health care agency. Service and education collaboration also provides a means of increasing the relevance of the curriculum. Congruence among the clinical learning environment, the program and the students' learning objectives is a natural and positive by-product of collaboration between clinical staff and faculty. Faculty involved in clinical practice develop an appreciation for the demands placed on clinical staff, and are able to work with the staff, helping them to promote their professional development in client care, teaching and research. Supervision of students in clinical practice thus becomes a mutually rewarding experience for staff, students and faculty.

Clinical practice enables the faculty member to maintain or improve professional competence. As well, it permits the nurse to increase credibility as an educator and a practitioner by providing a focus for scholarly activities and access to a patient population for research. Therefore, an important potential outcome for faculty is the achievement of academic expectations.

Characteristics of Faculty Practice

Faculty practice includes such direct care activities as indepth client assessment, nursing diagnoses – and the planning, implemenation and

evaluation of nursing care for individuals and their families. Indirect care functions include consultation around client care issues and the facilitation of the professional development of staff. The nurse faculty member, as a health professional, is accountable for his or her practice. Client care activities performed by faculty should contribute significantly to the health care of the individual and be documented on the health record.

Clinical practice, as an integral component of the faculty role, contributes to the goals of academia. The practice, therefore, should be scholarly in orientation, should demonstrate the application of scientific knowledge, and should result in research and publications. Recognition of practice by the university provides the faculty member with the opportunity to meet requirements for tenure and promotion.

Supervision of students in clinical practice, or in the occasional clinical activities that are utilized to develop skill or to orient oneself to the learning environment, does not meet the criteria for faculty practice. The purpose of such activities is to facilitate student learning. They do not address the expectations for scholarship or for quality of patient care.

Types of Faculty Practice

Historical

Faculty practice is a recent development which has evolved as a result of separation of nursing service and education. Practitioners of nursing, who served as role models for beginners in the apprenticeship system that characterized the first 50 years of nursing in North America, could not be described as faculty. The nurse educators who emerged following the movement of nursing education from hospitals to educational institutions, after the Second World War, assumed responsibility only for the teaching of nursing. Nursing service maintained responsibility for the practice of nursing.

In 1956, Dorothy Smith sought and received a dual appointment as Dean of the College of Nursing at the University of Florida and Director of Nursing of the associated new health centre. She set the trend for collaboration between nursing service and education. Schools of nursing began to be seen as places where nursing was taught and practised (Fagin, 1986; p. 142). The literature cites three recognized models of service and education collaboration which have been developed over the past 15 years in order to facilitate and support faculty practice. The unification models established in 1972 at Rush Presbyterian University (Christman, 1979) and at the University of Rochester (Ford, 1980) link the administrative

structures of nursing service and education. Teacher-practitioners are responsible to the one central administration for practice, teaching and research. Despite their strengths, these unification models have not been widely replicated because of the autonomous nature of most health care institutions and universities. The lack of provision for tenure for faculty/practitioners also makes these models unacceptable to many nursing faculty members in more traditional academic settings.

The interinstitutional model, established at Case Western Reserve University in 1961, provides a more flexible approach (MacPhail, 1983; p. 642-644). The system of clinical/academic appointments established in Cleveland influenced the subsequent development of other programs, including that of McMaster University. In this system, the service agency and the university develop guidelines together, producing a network of cross-appointments. They share responsibility for approving, creating, funding and terminating the positions. The service agency assesses the individual for the clinical appointment and negotiates clinical responsibilities. The university assesses the individual for a faculty position and defines expectations for tenure and promotion.

McMaster experience

At McMaster University, joint, associate and clinical cross-appointments in nursing, between the university and the service agencies in Hamilton, have existed since 1968. Joint university/agency appointments are those for which funding is shared by the contracting institutions, with one institution serving as paymaster and, thus, determining benefits and privileges. A more recent development has been the creation of geographic full-time (GFT) positions with the Hamilton-Wentworth Teaching Health Unit. These faculty positions are funded by the Ontario Ministry of Health and are located in the Regional Health Unit. They carry expectations for participation in practice, education and clinical research. Faculty in joint appointments at McMaster hold full-time faculty positions, although this is not necessarily the case in other examples of the collaboration model.

The clinical nurse specialist is the most common clinical role of those faculty currently holding joint appointments. Commitments for service activities vary from 25 to 60 percent of the appointee's time; the most common service/academic time ratio being 50/50. All are involved in direct and indirect client care activities. Clinical teaching of students in the established practice setting is also expected of all joint appointees. Students' learning experiences usually involve the clients of the joint appointee from the in-patient unit, the clinic or in the community.

Most joint appointees are involved with the development and evaluation of clinical projects. Many are currently participating in research projects which are primarily collaborative in nature. One outcome of several of these activities has been the promotion of interagency collaboration. Examples of recent clinical and research activities of faculty with the Teaching Health Unit include:

1. The development and implementation of critical appraisal work-shops for the nursing management team;
2. work with staff nurses to develop research proposals and submit them for funding
    a. to evaluate an educational program designed to decrease the mis-use of infant car seats,
    b. to evaluate the effects and costs of a hospital public health nurse liaison program;
3. the development of a health education and health promotion program for immigrants attending English as a Second Language class in Hamilton-Wentworth (600 students are currently enrolled in this program);
4. the organization of a workshop on nursing theory for community health nurses; and
5. the development of geriatric client assessment and care plan forms.

Associate appointments are granted to university-funded faculty by service agencies. Faculty holding these appointments are involved in direct client care or consultation. Practice commitments usually involve half to one day per week, in clearly defined roles such as: consultant to the Intensive Care Unit; or practitioner in specialty clinics or clinical programs, for example, the chronic pain clinic and perinatal program.

Clinical appointments are those given by the university to nursing staff that are funded by a service agency that the appointees contribute to the educational and research programs in the School of Nursing. Most clinical appointees act as clinical preceptors to Level Four B.Sc.N. students or to nurses who are enrolled in the graduate programs and serve as resources to students in their area of expertise. Clinical appointees are expected to meet university standards for promotion but, as no monetary commitment exists, are not granted tenure by the university. Access to university resources has stimulated a recent increase in research activities among some clinical appointees.

In addition, informal arrangements for faculty practice are made when formal appointment agreements do not exist with an agency, when consultation, a research project or clinical practice is negotiated for a time-limited period, and enable faculty to establish a clinical role which will lead to an associate appointment.

Trends

Shared appointments that are found in the models developed at Case Western Reserve University, Rush University and the University of Rochester have demonstrated that the academic/practitioner role does work. Criticisms of these models have been directed at the lack of research outcomes and at their institutional nature. Recent trends include arrangements for practice in community settings and greater emphasis on clinical research as an expected outcome of faculty practice. The geographic full-time faculty positions, established with the Teaching Health Unit and McMaster University, provide an example of faculty practice in the community with research as an expectation.

The Robert Wood Johnson Nurse Faculty Fellowships in Primary Care Program was established in 1977 to help prepare nursing faculty for leadership roles in primary nursing, with emphasis on research, primary care curriculum development and clinical competence (Mauksch, 1985; p. 142). The Foundation is currently sponsoring a Clinical Nurse Scholars Program which is exemplified by the theory-based practice established by Sister Callista Roy. She views research, patient care and education as being integrated in the one role of clinical nurse scholar (Roy, 1985; p. 200). Both programs have contributed to the development of leaders in academic nursing practice.

Faculty group practices, now found in the United States, are another viable model for the integration of nursing practice, research and education. In a survey of 23 group nursing practices, Rosswurm (1981) found that they provided greater flexibility in schedules, and were generally incorporated within a health care agency. The seven practices in the group that were based on a particular nursing theory ranked highest in clinical research.

There are many examples in the literature of independently arranged professional faculty practice. Most such arrangements occur within teaching hospitals or university affiliated clinics.

Other types of practice may be described as "faculty who practise" as opposed to faculty practice. These take the form of dual appointments, independent practice and moonlighting. They hold no expectations for the integration of scholarship and teaching with the practice role, although such outcomes may result. These arrangements usually occur when the education and service institutions have no established mechanisms for collaboration.

Factors Hindering Faculty Practice

Professional traditions, institutional bureaucracies, lack of structure and support for practice activities and personal risk all hinder the development of faculty practice.

The traditional split between nursing service and education has lead to a separation of the educator and practitioner roles. Nurses with research preparation are primarily found in the academic settings. In the past, nursing research has focused on learning and learners and on nursing administration. Research that is related to the practice of nursing is a more recent development. Nursing faculty have become physically isolated from the realities of the practice setting. They lack responsibility for the quality of nursing care and authority to influence it. They are dependent upon service administrators and physicians to gain access to clients who will be subjects for student learning, practice and research. As guests in the practice setting, they lack credibility as practitioners.

Differences in the structure and function of service and academic institutions are also a hindrance. Most health care institutions and universities are independent organizations. Few settings provide an environment conducive to the establishment of shared positions in nursing. The bureaucratic structure of hospitals makes it difficult for nurses to be autonomous practitioners, with control over their time and activities. The division of time and energy between two systems can result in work overload and a sense of not belonging to either system (Joel, 1983; p. 53). Client care activities often lack flexibility and may conflict with teaching or research responsibilities.

In service settings, where patient care is the primary concern, directors of nursing may not perceive a need for the expertise of faculty and may not value clinical nursing research. The financial constraints of the health care system also limit scholarly activities which are often viewed as extraneous.

Interagency agreements for faculty practice exist only in a few settings, most of which are in health sciences centres. When formal structures are absent, faculty wishing to practise must obtain support from both the dean of nursing of the university and from the director of nursing service. Roles, responsibilities, time commitments and reimbursement must be negotiated and arranged.

The establishment of interagency agreements for faculty practice takes time and a great deal of effort. Pre-existing expectations in both settings and expectations of individual faculty must be altered in order for faculty to

integrate practice successfully into their traditional role and for nursing service to utilize these additional resources to best advantage. Smith, following her experiences at the University of Florida, identified the failure to apply role theory and theories of planned change to the process of development of the unification/collaboration models as a major failure (MacPhail, 1983; p. 642).

Apprehensions in the education setting that deter faculty practice include lack of peer support and expectations of work overload. Anderson and Pierson (1983), in an exploratory study of the views of baccalaureate faculty engaged in practice, identified perceived work overload as the greatest inhibitor to undertaking practice. They questioned this perception when they found no difference between the working hours of faculty in the unification model group and those in traditional settings. This discrepancy between perceptions of workload and actual working hours was attributed to the fact that one-third of the faculty in the non-unification model group did their practice during the summer. The sense of frustration experienced by the unification model group in mastering the expectations for the dual roles may have contributed to their perceptions of work overload (Anderson & Pierson, 1983).

Universities, in turn, have not traditionally recognized clinical practice activities for tenure and promotion. Faculty are expected to be clinically competent as part of their educator role in the clinical supervision of students. Client care activities may be viewed as an additional function and considered as service to the community. Few schools of nursing have formal practice policies, requirements or remuneration policies (Andreoli & Musser, 1986). Two classes of faculty are created: the academic stream leading to tenure and the non-tenured clinical group. The resulting tendency to reward research over practice reinforces the idea that practice is an appendage to the usual faculty role.

Inconclusive evidence about the research outcomes of faculty practice may further inhibit faculty from seeking practice. Evaluation of unification/ collaboration models has been limited. Supporters of faculty practice point out that, when the schools at Case Western Reserve, Rush and Rochester were measured by external raters against the total population of U.S. schools, all were ranked in the top 20 in terms of publication records and professional prestige (Ford, 1985; p. 200). Christman (1985) attributed to youth the tendency of Rush faculty members to publish primarily in clinical journals. As evidence of greater productivity, he cited the fact that 72 research investigations were in progress. Experience of the authors of this report support the assumption that faculty who are beginning practice spend much of their initial time creating an environment that is

conducive to clinical research. Research productivity may, therefore, be limited initially, but should increase with experience. At McMaster University, where almost all faculty are involved in some type of clinical practice, research productivity has not been hindered and may, in fact, have been increased. In 1983-84 research grants to the McMaster University School of Nursing from the major funding agencies constituted approximately two-thirds of the total funding received by the nine Ontario university schools or faculties of nursing (Mohide & O'Connnor, 1986). Twelve (68.4%) of the 19 funded and unfunded studies listed for McMaster School of Nursing related to clinical practice. Of the 41 research projects listed for the 9 Ontario university schools or faculties, 55.4 percent were categorized as clinical.

Strategies for Facilitating Faculty Practice

Table 1 lists important strategies for encouraging and facilitating faculty practice. Administrative support has been found to be the greatest means of encouraging faculty practice (Anderson & Pierson, 1983). This is essential if existing expectations are to be altered. Dickens (1983) concluded, from a survey of nurse administrators for baccalaureate and higher degree schools of nursing in the southeastern United States, that support for career development and role transition was the most important for faculty members to maintain practice activities.

Collaboration between nursing service and education is essential for the development of a structure for faculty practice and a supportive environment. Patient populations are more accessible through systems of clinical/academic appointments. A faculty member who has a formal appointment can avoid the potential problems of control of access to patients by physicians and of competition with other health professionals for clinical resources. Funded positions, such as the geographical full-time faculty appointments, provide greater job security for the faculty member because the positions are permanent and expectations for practice, research and teaching are clearly defined.

Recognition of clinical practice activities as a requirement for tenure and promotion is essential. Strategies to promote clinical practice include the establishment of guidelines by the school or faculty of nursing, and clear communication of the need for all faculty who teach students clinically to have practice involvement. If practice is not seen as a requirement, making the option available to those members wishing to pursue this route to advance their scholarly work will enable individuals to concentrate their strengths on their own career development. Each faculty member should have the opportunity to develop a career path that is

appropriate for his or her specific needs and skills. In many universities, much work needs to be done for practice to be recognized as part of the professional role of faculty in practice disciplines. Faculties of health sciences and universities with other health professional programs are generally more supportive of this work.

If practice is to be recognized as contributing to the goals of academia, nurse faculty members must demonstrate valid scholarly outcomes from their practice activities. Research projects, publications and presentations are tangible results which can be evaluated by peers as part of the tenure and promotion process. Outcomes such as the impact on patient care, curriculum development and the quality of student learning are very important, but may be more difficult to demonstrate.

Table 1

Strategies for Facilitating Faculty Practice

1. Administrative support
2. Collaboration between service and education
3. Structural mechanisms
4. Job security
5. Recognition of practice for tenure and promotion
6. Demonstration of scholarly outcomes
7. View of practice as integral to faculty role.
8. "Risk taking" and initiation of innovative approaches by faculty
9. Integration of research, teaching and practice activities

Faculty practice is facilitated when faculty members view practice as an integral part of the faculty role and not as an additional responsibility. In an ideal situation, the faculty member should interact simultaneously with patients, students and staff nurses in a clinical setting where he or she is also conducting a clinical research project.

To establish a practice base, the faculty member must find a suitable clinical setting, negotiate goals and job expectations, demonstrate clinical competence and reliability, and establish cooperative and trusting relations with the staff in the setting. The faculty member therefore must be goal directed, willing to take risks, innovative and must demonstrate professional credibility. The individual must be able to work collaboratively within a second system, which may be more bureaucratic in nature and have different values than the university system. Participation in the decision-making process of each institution is key to integration in the two social systems. Realistic expectations help the faculty member to integrate clinical practice into an academic schedule.

Conclusions

Practice is an achievable expectation for faculty in a practice discipline. The development of a practice base is hindered by the traditional separation of nursing service and education; by the autonomous nature of the institutions; and by the absence of mechanisms for access to clients, reimbursement for service and negotiation of roles and functions. Administrative support and collaboration between service and education are essential for the achievement of faculty practice. Individual faculty must be goal directed, innovative and willing to take risks if they are to develop a realistic and successful practice. They must demonstrate clinical competence, and must be able to work collaboratively with a variety of people with differing values and expectations.

Practice, viewed as an integral component of the faculty role, can help achieve the goals of academia. Practice activities that demonstrate scholarship in the form of research projects, publications and presentations meet the criteria of universities for tenure and promotion. Formal recognition of practice by sectors outside the health disciplines in some universities may require further negotiation and demonstration of the academic nature of practice. Faculty practice promotes collaboration between nursing service and education and can have beneficial results for student learning, the quality of patient care, faculty satisfaction and career development.

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RÉSUMÉ

La pratique des soins infirmiers: le dilemme des responsables de la formation du personnel infirmier

La pratique des soins infirmiers fait partie intégrante du rôle des professeurs de sciences infirmières et devrait donc contribuer à la réalisation des objectifs universitaires, en permettant la réalisation de travaux de recherche et d'autres activités universitaires. La pratique doit également favoriser la qualité du programme d'enseignement et influer sur l'apprentissage en clinique; elle doit donc relever la qualité des situations d'apprentissage que vit l'étudiant. La pratique des sciences infirmières par les professeurs doit également contribuer à la qualité des soins dispensés aux malades et favoriser un rapprochement des soins infirmiers et des sciences infirmières. Le professeur de sciences infirmières qui tente d'asseoir son enseignement sur la pratique se heurte aux obstacles résultant inévitablement de la séparation traditionnelle des soins infirmiers et des sciences de l'éducation, ainsi qu'à une reconnaissance insuffisante, dans certains établissements d'enseignement, du rôle que joue la pratique. L'auteur présente des stratégies qui facilitent la pratique des soins infirmiers par le professeur de sciences infirmières et l'intégration de la pratique dans le rôle professionnel global, de manière à lui permettre d'atteindre un niveau de compétence professionnelle et d'assurer son avancement universitaire.