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# Should nurse academics engage in clinical practice?

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**Summary** The education of nurses has traditionally been conducted in the hospital based setting. This changed over the last few decades, with nursing education now being a tertiary based course in many countries. There were numerous reasons for this move, the main goal being to improve the educational experience of students and thus the competence of graduates. Nurse academics whose role is to educate students are faced with the challenge of ensuring their teaching reflects the contemporary nursing environment. One way of doing this is by actively engaging in clinical practice. However there are arguments for and against (as well as barriers to) them doing so and little empirical evidence to support either argument. Individually, nurse academics must make a decision about whether engaging in clinical practice is beneficial to their career and the students they teach.

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## Introduction

Historically, the education or training of nurses has been conducted in the apprenticeship-style hospital based setting. This educational model was characterised by paid on-the-job-training but with little educational direction and ill-defined outcomes (Mallaber and Turner, 2005). Clinical teaching and

learning were taken for granted, their purpose unquestioned (Mannix et al., 2006). Nursing students were often counted in staffing numbers and thus seen as an 'extra pair of hands' rather than a learner with specific needs (Maslin-Prothero and Owen, 2001). In this environment, there was greater emphasis on practice rather than theory and 'task accomplishment' rather than educational outcomes.

In the latter stages of the last century however, this started to change. In North America, nursing education moved from the hospital environment

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to the tertiary sector in the 1960s. In Australia this move occurred in the 1980s and in the UK, the mid 90s (Mallaber and Turner, 2005). The move to the tertiary sector put greater emphasis on the acquisition of skills and knowledge, rather than solely relying on the amount of time spent at the bedside as an indicator of a student's competence (Mallaber and Turner, 2005).

With this move, many hospital-based nurse educators found they became academics 'overnight', as their employer changed from a hospital or health service to a university. Many of these educators therefore became 'refugees', finding themselves in unfamiliar territory and not having engaged in direct patient care for some years. Many had also never engaged in scholarly activities such as research and publication. The move to the tertiary sector resulted in these educators being required to demonstrate an advanced level of knowledge regarding the theory and practice of nursing (Murray and Thomas, 1998). It meant adopting new standards for defining education, moving from a product focus to a more process-oriented approach (Mallaber and Turner, 2005).

Today, the education of nurses primarily occurs in the tertiary sector. The main educators of nursing students (i.e. academics) are no longer based in hospitals. This creates a barrier to academics continuing contact with the clinical environment and maintaining clinical credibility or competence. Academics are also expected to do much more than nurse educators of the past. Not only are they expected to teach, they are also expected to engage in scholarly activities such as research and publication. These role priorities make it difficult for nurse academics to 'keep in touch' with contemporary nursing practice, and raise the question of whether they even need to.

There are arguments for and against nurse academics engaging in clinical practice. In this paper, both these arguments will be presented. The aim of this paper is to stimulate debate about this challenging professional issue and provide a framework for further discussion and consideration by academics and other senior members of the profession.

## Defining clinical practice and clinical credibility

Before the arguments for and against nurse academics engaging in clinical practice can be made, a definition of clinical practice needs to be established. Miller (1997) provided a broad definition, suggesting that clinical practice includes direct or

indirect nursing services. Whilst this definition is non-specific, it suggests that clinical practice does not just include direct patient care. The definition proposed by Rudy et al. (1995) though encapsulates the more commonly held definition. Their definition states that clinical practice involves participation in and responsibility for direct patient care.

Clinical practice must also be differentiated from 'faculty practice', which places it into an academic context. Faculty practice is a concept described in the North American literature and reflects a formal arrangement between academic schools of nursing and clinical agencies such as hospitals (Saxe et al., 2004). Within this concept, a variety of 'practice models' have been implemented, with academics engaging in clinical practice in the 'partner' institution and this being incorporated into academic workloads (Budden, 1994). The models of faculty practice reflect the broader definition of clinical practice, with some involving direct patient care, others guiding students' clinical experience, and others involving a more consultative role for clinical staff. Thus, Campbell's (1993) definition embraces the totality of potential within the role, with faculty practice being the delivery of nursing care through the advanced behaviours of research, mentoring, leadership, collaboration, and direct patient care, resulting in scholarship and student learning.

In the United Kingdom, the positions of lecturer practitioners and link teachers have been created in the tertiary sector as models for incorporating clinical practice into the academic role (Cave, 2005). The extension of the concept of clinical involvement within these roles has included facilitating the clinical experience for students and clinical staff and assessing the theory practice connection within the clinical environment, without providing direct patient care (Brown, 2006).

Further to these interpretations of clinical practice, the concepts of clinical credibility or clinical competence also need clarification, as a variety of definitions exist and the terms are often used interchangeably. Fisher (2005) found that when these terms are used in regard to nurse academics, they almost always refer to recently engaging in patient care. Such definitions imply that the simple act of providing nursing care to a patient somehow guarantees or ensures that one is competent. Acton et al. (1992) however provided an alternate definition, stating that clinical competence is simply having expert knowledge of a particular field. In their discussion of the clinical nurse tutor debate, Acton et al. (1992) defined credibility as the quality of being worthy of belief or trust. This highlights the inference that exposure to the clinical environment

implies a greater level of trustworthiness with regards to the information being delivered in a classroom. However, for the purposes of this paper, clinical practice is defined as a nurse actively engaging in direct patient care. This may include patients in a hospital or any other health care agency such as a community based health centre.

## The arguments for

Murray and Thomas (1998) argued that if theory is to link with practice and practice is to inform lecturers' theoretical input to nursing students, those who teach must be clinically credible. Academics in their department who engaged in clinical practice reported that by doing so, they gained insight into the current clinical, cultural and technological issues of contemporary practice, which then influenced their teaching. Nahas (2000) and Cave (2005) similarly argued that nurse academics need to be more aware than ever of the clinical realities that could and should affect the application of the theory they teach.

Nurse academics must be aware of the knowledge and skills the students they are teaching require in the clinical area. One way of achieving this is by engaging in clinical practice themselves. Krafft (1998) stated that rapid technological changes in the healthcare arena and increased patient acuity demand that academics demonstrate confidence, innovation and creativity in their understanding of both traditional and non-traditional practice settings.

By continuing to work in the clinical area, academics are obviously gaining valuable experience which can directly inform their teaching. Fawcett and McQueen (1994) for example stated that clinical anecdotes and examples help to bring theory alive in the formal learning environment, so that situations or theory can be more easily visualised. They also argued that the reality and stresses of clinical work cannot be fully appreciated by those who are not clinically involved. Similarly the nurse academics in Fisher's study (2005) felt that 'being visible' in the clinical area allowed them to keep abreast of the political climate and organisational issues.

Bentley and Pegram (2003) expressed a similar desire to 'create reality' in their teaching by actively engaging in clinical practice. They described their experiences as students of lecturers who use out-dated examples or who were not able to appreciate the changing context of contemporary nursing practice. McNeil and Mackey (1995) suggested that clinical practice is an excellent

opportunity to ensure that faculty are up-to-date academicians as well as clinically competent practitioners. Saxe et al. (2004) similarly argue that clinical practice provides an opportunity for academics to maintain and enhance their skills, which may augment their mentoring skills for students.

Krafft (1998) suggested that by engaging in clinical practice, academics can help to bridge the division between nursing education and service that occurred with the move into the tertiary sector. The existence of a theory practice gap has commonly been discussed in nursing literature (e.g. Brasell-Brian and Vallance, 2002; Landers, 2000). By engaging in clinical practice, academics can help bridge this gap. Krafft (1998) for example indicated that engaging in clinical practice helps enhance the clinical relevancy of the nursing curriculum to contemporary nursing practice.

Apart from teaching, a major part of an academic's role is engaging in research. Allen (2000) stated that research questions that are topical and or relevant to nursing are more likely to emerge during the course of clinical activity. The same argument has been made by other authors (e.g. Fawcett and McQueen, 1994; Charlesworth et al., 1992). These authors suggested that nurse academics who engage in clinical practice would also be able to support and guide clinical staff in undertaking and implementing research. This however does not provide an immediate or obvious benefit to academics. It does though strengthen the relationship that universities have with clinical agencies.

Irrespective of the educational reasons for academics engaging in clinical practice, there is an expectation by university students that they will get value for their money. Unlike students of the past, today's students pay for their education and university fees are not cheap. The demand for quality education in the classroom in return for the time and money spent is therefore high (Nahas, 2000; Barnes et al., 1994). Academics thus need to ensure that their teaching is preparing students for the realities of clinical work. Engaging in clinical practice can reassure academics that this is happening.

## The arguments against

It is difficult to argue that nurse academics should not engage in clinical practice. To do so, such an argument would need to suggest that engaging in clinical practice is in some way harmful or detrimental. Instead, the argument presented here is that it is unnecessary for nurse academics to engage

in clinical practice. The barriers to doing so, as well as the prohibiting factors, are also presented.

Being a full time academic and engaging in clinical practice places academics under a great deal of pressure. Allen (2000) for example reported the results of a research project where a nurse academic engaged in clinical practice one day a week for six months. The academic involved expressed anxiety and a lack of confidence in doing so and found it difficult to balance her clinical and academic workloads. She found the experience tiring as her academic duties were not reduced and she effectively became a servant to two masters. Allen (2000) reported very few benefits to the academic involved. This conflict between dedicating time to teaching and to clinical practice has also been described by other authors (e.g. Clifford, 1999; Forrest et al., 1996; Ward, 2001) and highlights the challenge faced by academics who try to do so.

Murray and Thomas (1998) said that if clinical credibility of academics is to become a reality, educational institutions must examine innovative approaches to facilitate this. It is neither realistic nor reasonable to expect academics to engage in clinical practice in their own time. They must be given opportunities for clinical practice at designated times in their normal working week (Nahas, 2000). Academics have reported that the reasons they do not engage in clinical practice are heavy workloads, lack of time and the poor recognition given to clinical practice (Budden, 1994; Nugent et al., 1993). If academics are going to engage in clinical practice, the organisational and individual commitment must be explicit, and there should be a recognisable and integrated programme aimed at the maintenance and advancement of credibility in the clinical field (Acton et al., 1992). Failure of universities to provide academics with time to engage in clinical practice or failing to reward this work, discourages them from doing so.

Richie et al. (1996) suggested that awarding workload credit for clinical practice validates its importance. They further argued that it is neither realistic nor expected that workload allocations occur unless income generated is commensurate with the portion of time spent in clinical practice. If clinical practice is included in nurse academics' workloads, universities will expect there to be some benefit in doing so. Even if the benefit to the university is not financial, a benefit will be expected.

The definitions of clinical credibility also highlight the requirement to be specialists in a particular field of nursing, with extensive experience in that area. It could be argued that the belief that nurse academics should have an expert knowledge

of a particular clinical area is not only unrealistic, but also impossible. The amount of time that would be required to be spent within the clinical environment in order to maintain specialist knowledge would be difficult to negotiate within the workload and expectations of academia (Acton et al., 1992). Additionally, Zungolo (2004) found that specialization in one field of nursing actually impedes the academic's ability to provide a comprehensive and sufficiently generalised knowledge base suited to the novice registered nurse.

What is taught in the classroom obviously needs to prepare the student for the realities of the clinical environment. But simply engaging in clinical practice does not guarantee that 'knowledge transfer' will occur. For example, research (e.g. Bilgin et al., 2000; Harper, 2004; Popovich et al., 2004) has found that despite using a pulse oximeter for many years, experienced clinicians lacked an understanding of the theoretical principles needed to use this technology correctly. For these clinicians, the simple process of using an oximeter on a regular basis did not result in an understanding of its correct use, and the same could be said of academics who sporadically engage in clinical practice.

It can therefore be argued that the process of engaging in clinical practice does not guarantee that new knowledge or competence will be acquired or further skills developed. Even if it did, it would only allow the development of a small and focussed amount of knowledge, pertinent to that particular area of clinical specialty. Not every patient is managed in the same way and every specialist medical practitioner has their own unique way of managing patients. This is one of the reasons that the evidence-based practice movement evolved (e.g. Fineout-Overholt et al., 2005). It is far more important for academics to be teaching students correct principles rather than just one particular way of managing patients, a way that they may have been exposed to whilst engaging in clinical practice, but a way that may be based on ritual rather than on sound evidence (Walsh and Ford, 1989).

Fisher (2005) argued that the ability to apply theory to practice in an educational environment gives academics clinical credibility. She concluded that nurse academics must retain the capacity to support education at the interface between practice and theory. As academics are expected to be researching and have the ability to critique research, they can use their unique role as researcher and teacher to educate students about best practice. Actively engaging in clinical practice does not guarantee that academics will be exposed to



best practice. But engaging in research helps them identify what best practice actually is.

## Discussion

The role of an academic typically involves teaching, research (including publication) and a 'service contribution' (e.g. administration of an academic programme). Universities often emphasize accomplishments in scholarship and research over contributions to service (Worrall-Carter and Snell, 2004; Tabak et al., 2003). The main criterion for tenure in an academic position is generally not clinical excellence (Nahas, 2000). Nurse academics are therefore not encouraged to engage in clinical practice and may ask themselves why they would bother doing so, when there is more to gain by spending their time researching and publishing. Nearly a third of the 1489 academics surveyed by Ramsden et al. (1995) felt that teaching was valued 'little or not at all' by their university. Ward (2001) went so far as to suggest that academics who focus their teaching activities on clinical supervision of students and engaging in clinical practice, are often not on the correct path towards tenure. The rewards or incentives for engaging in clinical practice are therefore few or non-existent.

A number of authors (e.g. UKCC, 1999) have argued that nurse academics should be clinically competent. However given that the main roles of academics are teaching and research, this argument is questionable. What is important though is that their teaching reflects current clinical practice and prepares students for the realities of the clinical area. In order to do this, academics first and foremost, need to be skilled educators, as opposed to skilled clinicians.

Ramsden (2003) described six key principles of effective teaching in higher education. These principles are: interest and explanation; concern and respect for students and learning; appropriate assessment and feedback; clear goals and intellectual challenge; independence, control and engagement; and learning from students. His discussion of these principles did not refer to the knowledge base of academics, their engagement in contemporary practice or their comprehension of the material being taught. Instead the emphasis is on teaching skills and approaches. Perhaps the underlying assumption is that by their very nature, academics have a sound knowledge base of their chosen discipline.

Prosser and Trigwell (1999) also described principles underlying good teaching. These are teachers: being aware of the way they conceive teaching;

examining the context in which they teach; being aware of the way students perceive teaching; and continually revising and developing their teaching in light of this. Again there was no mention of the teacher's knowledge base in this description or of the teacher being aware of or engaging in contemporary practice. Possibly the only reference made by Prosser and Trigwell (1999) to contemporary practice is 'the context in which teachers teach'. But again this does not imply that academics should be practicing what they teach.

If academics are going to engage in clinical practice, it must be acknowledged in their workloads. Failure to do so discourages loyalty and retention of staff. The question of what is to be gained by nurse academics engaging in clinical practice also needs to be asked. Academics have a 'solid grounding' in the discipline of nursing as evidenced by having an undergraduate degree (and often other postgraduate qualifications), complimented by years of clinical experience and other accomplishments (e.g. research). Academics can keep in touch with new developments in patient care in numerous ways, such as by reviewing relevant literature (e.g. peer-reviewed journal articles) or attending conferences.

Barnes et al. (1994) suggested that making clinical practice compulsory for academics as a means of maintaining clinical skills may be counter-productive. If clinical practice was mandatory and thus included in academics' workloads, they would be less available to students and less available to contribute to managerial or administrative tasks, which are also part of an academic's role. The quality of their academic work may also decline due to the fatigue resulting from shiftwork. They may therefore struggle to meet traditional requirements for promotion or tenure (Krafft, 1998). One academic (Ward, 2001) reported that although engaging in clinical practice was in her job description, it was not a criterion for promotion or tenure.

Little empirical evidence could be found to support the arguments for or against nurse academics engaging in clinical practice. Perhaps a more realistic and achievable goal is that nurse academics strive to maintain what Fisher (2005) called clinical currency and awareness. She felt this term more meaningfully captures the essence of contemporary nursing practice, rather than the obscure terms clinical credibility and competency. Crotty (1993) similarly argued that the focus should be on updating theoretical knowledge and skills, rather than being able to perform as an expert practitioner. This is particularly the case if academics are considered to be nurse scholars rather than nurse clinicians.

## Conclusion

Should nurse academics engage in clinical practice? There is no empirical evidence which proves or supports the argument that they should. Most of the arguments are based on opinion. If the answer is yes, then there must be an obvious benefit to academics and their students. So far, there is no evidence to support this. Similarly there is no strong evidence that suggests nurse academics should not engage in clinical practice. However if it is not part of their academic workload and there is no career benefit in them doing so, then academics are unlikely to pursue it in their own time.

At the present time, it seems left up to the individual academic to decide whether engaging in clinical practice is worthwhile. And whilst clinical practice is not acknowledged in workloads or promotion criteria, academics will tend to focus on activities for which there are more immediate or obvious benefits. More than a decade ago, [Acton et al. \(1992\)](#) argued that the widespread organisational, financial, emotional and philosophical changes required to 'make' nurse academics clinically credible are not likely to change in the foreseeable future. From this review of the literature, it would seem that their prediction was correct.

## References

- Acton, L., Gough, P., McCormack, B., 1992. The clinical nurse tutor debate. *Nursing Times* 88 (32), 38–40.
- Allen, D., 2000. Faculty practice: a model to bridge the theory-practice divide. *British Journal of Community Nursing* 5 (10), 504–510.
- Barnes, N., Duldt, B., Green, P., 1994. Perspectives of faculty practice and clinical competence. *Nurse Education* 19 (3), 13–17.
- Bentley, J., Pegram, A., 2003. Achieving confidence and competence for lecturers in a practice context. *Nurse Education in Practice* 3 (3), 171–178.
- Bilgin, H., Kutay, O., Cevheroglu, D., Korfali, G., 2000. Knowledge about pulse oximetry among residents and nurses. *European Journal of Anaesthesiology* 17 (10), 650–651.
- Brasell-Brian, B., Vallance, E., 2002. Clinical practice/education exchange: bridging the theory practice gap. *Nursing Praxis in New Zealand* 18 (1), 17–26.
- Brown, S.J., 2006. The experiences of lecturer practitioners in clinical practice. *Nurse Education Today* 26 (7), 601–608.
- Budden, L., 1994. Nursing faculty practice: benefits vs costs. *Journal of Advanced Nursing* 19 (6), 1241–1246.
- Campbell, M., 1993. Multidisciplinary faculty practice and community partnership. *Holistic Nursing Practice* 7 (4), 20–27.
- Cave, I., 2005. Nurse teachers in higher education – without clinical competence, do they have a future?. *Nurse Education Today* 14 (5) 394–399.
- Charlesworth, G., Kanneh, A., Masterson, A., 1992. Nursing is a practice-based profession and tutors must retain clinical expertise. *Nursing Times* 88 (32), 40–41.
- Clifford, C., 1999. The clinical role of the nurse teacher: a conceptual framework'. *Journal of Advanced Nursing* 30 (1), 179–185.
- Crotty, M., 1993. Clinical role activities of the nurse teacher in Project 2000 program. *Journal of Advanced Nursing* 18 (3), 460–464.
- Fawcett, T., McQueen, A., 1994. Clinical credibility of the nurse teacher. *Nurse Education Today* 14 (4), 264–271.
- Fineout-Overholt, E., Melnyk, B., Schultz, A., 2005. Transforming health care from the inside out: advancing evidence-based practice in the 21st century. *Journal of Professional Nursing* (6), 335–344.
- Fisher, M., 2005. Exploring how nurse lecturers maintain clinical credibility. *Nurse Education in Practice* 5 (1), 21–29.
- Forrest, S., Brown, N., Pollock, L., 1996. The clinical role of the nurse teacher: an exploratory study of the nurse teacher's present and ideal role in the clinical role. *Journal of Advanced Nursing* 24 (6), 1257–1264.
- Harper, J., 2004. Post-anesthesia care unit nurses' knowledge of pulse oximetry. *Journal for Nurses in Staff Development* 20 (4), 177–180.
- Krafft, S., 1998. Faculty practice: why and how. *Nurse Educator* 23 (4), 45–48.
- Landers, M., 2000. The theory-practice gap in nursing: the role of the nurse teacher. *Journal of Advanced Nursing* 32 (6), 1550–1556.
- Mallaber, C., Turner, P., 2005. Competency versus hours: an examination of a current dilemma in nurse education. *Nurse Education Today* 26 (2), 110–114.
- Mannix, J., Faga, P., Beale, B., Jackson, D., 2006. Towards sustainable models for clinical education in nursing: an on-going conversation. *Nurse Education in Practice* 6 (1), 3–11.
- Maslin-Prothero, S., Owen, S., 2001. Enhancing your clinical skills and credibility: the role of nurse lecturers and teachers in clinical practice. *Nurse Education in Practice* 1 (4), 189–195.
- McNeil, N., Mackey, T., 1995. The consistency of change in the development of nursing faculty practice plans. *Journal of Professional Nursing* 11 (4), 220–226.
- Miller, V., 1997. Co providing continuing education through faculty practice: a win-win opportunity. *Journal of Continuing Education in Nursing* 28 (1), 10–13.
- Murray, C., Thomas, M., 1998. How can the clinical credibility of nurse lecturers be improved? *British Journal of Nursing* 7 (8), 490–492.
- Nahas, V., 2000. Maintaining clinical credibility as a nurse teacher in a postgraduate tertiary specialization program. *Clinical Nurse Specialist* 14 (4), 184–188.
- Nugent, K., Barger, S., Bridges, W., 1993. Facilitators and inhibitors of practice: a faculty perspective. *Journal of Nursing Education* 32 (7), 293–300.
- Popovich, D., Richiuso, N., Danek, G., 2004. Pediatric health care providers' knowledge of pulse oximetry. *Pediatric Nursing* 30 (1), 14–20.
- Prosser, M., Trigwell, K., 1999. *Understanding Teaching and Learning – The Experience of Higher Education*. Society for Research into Higher Education, Buckingham.
- Ramsden, P., 2003. *Learning to Teach in Higher Education*, second ed. Routledge Falmer, London.
- Ramsden, P., Margetson, D., Martin, E., Clarke, S., 1995. *Recognising and Rewarding Good Teaching in Australian Higher Education*. Australian Government Publishing Services, Canberra.
- Richie, M., Adams, S., Blackburn, P., Cone, C., Dwyer, K., Laben, J., Seidel, S., 1996. Psychiatric nursing faculty

- practice: care within the community context. *N & HC: Perspectives on Community* 17 (6), 317–321.
- Rudy, E., Anderson, N., Dubjak, L., Kobert, S., Miller, R., 1995. Faculty practice – creating a new culture. *Journal of Professional Nursing* 11 (2), 78–83.
- Saxe, J., Burgel, B., Stringari-Murray, S., Collins-Bride, G., Dennehy, P., Janson, S., Humphreys, J., Martin, H., Roberts, B., 2004. What is faculty practice? *Nursing Outlook* 52 (4), 166–173.
- Tabak, N., Adi, L., Eherenfeld, M., 2003. A philosophy underlying excellence in teaching. *Nursing Philosophy* 4 (3), 249–254.
- UKCC 1999, *Fitness for Practice*, UKCC, London.
- Walsh, M., Ford, P., 1989. Rituals in nursing – we always do it this way. *Nursing Times* (41), 26–35.
- Ward, K., 2001. Faculty clinical practice: strategies for implementation and evaluation. *Nursing Forum* 36 (4), 15–20.
- Worrall-Carter, L., Snell, R., 2004. Nurse academics meeting the challenges of scholarship and research. *Contemporary Nurse* (1–2), 40–50.
- Zungolo, E., 2004. Faculty preparation: is clinical specialization a benefit or a deterrent to quality nursing education? *The Journal of Continuing Education in Nursing* 35 (1), 19–23.

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