

ORIGINAL ARTICLE

Evolving the practitioner–teacher role to enhance practice–academic partnerships: a literature review

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Aims and objectives. The purpose of this article was to review the development of the practitioner–teacher model and its use in advancing clinical nursing.

Background. The practitioner–teacher role, or the unification model, incorporates clinical practice, teaching, consultation and research responsibilities for nurses serving in advanced clinical roles or as nursing faculty as part of professional nursing practice. The practitioner–teacher role facilitates a practice–academic partnership that can serve as a beneficial way to advance clinical nursing care.

Design. An exploratory literature review was conducted combined with review of practitioner–teacher and practice–academic exemplars.

Methods. A descriptive review of the practitioner–teacher model of nursing practice reveals that activities of the role include clinical nursing care, serving as a preceptor for nursing students in a focused area of expertise, consulting on patient care issues, presenting in-services and course lectures, and serving as a member of faculty and nursing division committees.

Results. The practitioner–teacher role lends itself to promoting practice–academic partnerships that combine clinical nursing care with professional nursing activities.

Conclusions. The model of practice, education, consultation and research of the practitioner–teacher position advances practice–academic partnerships.

Relevance to clinical practice. The practitioner–teacher model serves to optimise the way nursing practice and academic work together to integrate knowledge, scholarship, service and learning and to advance the profession and the discipline of nursing. This article discusses aspects of the unique practice–academic partnership using the practitioner–teacher model, how the role evolved, and how it can improve clinical nursing care globally.

Key words: clinical nursing, practitioner–teacher, professional nursing practice

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What does this article contribute to the wider global clinical community?

- Internationally, there is a focus on integrating clinical nursing research into clinical practice and on creating practice–academic partnerships
- This article highlights the unique role of the practitioner–teacher, a clinical nursing role that promotes evidence-based practice and research integration into clinical practice
- The practitioner–teacher role can help to promote clinical nursing care that is focused on professional nursing practice along with application of research and best care practices.

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Introduction

A renewed interest in practice–academic partnerships has evolved recently due to several forces promoting linkages to enhance nursing care and patient focused outcomes. The focus on integrating evidence-based practice in clinical nursing care, performance improvement initiatives, quality monitoring requirements and a focus on the Magnet Recognition Program® are a few of the current driving forces sparking the renewed interest in education and service partnerships. The Institute of Medicine report on *The Future of Nursing* highlighted the critical importance of all areas of nurses working together in partnership to optimise the nursing workforce (Institute of Medicine 2010).

Practice–academic partnerships can run the spectrum from informal relationships such as project-based consultations to formal partnerships that involve contracting dedicated educator positions to facilitate service or academic-based needs. Anchoring the extreme end of the continuum is total integration of education and practice into a single role.

This article discusses a unique practice–academic partnership termed the practitioner–teacher model and how this role has evolved in the USA and is used to improve the care delivered by clinical nurses.

Background: origins and history of the practitioner teacher role

One of the first introductions of the practitioner–teacher role was in 1972 at Rush University Medical Center in Chicago Illinois, USA, formerly Rush Presbyterian St. Luke's Medical Center, under the vision of Luther Christman PhD RN, who was the founding dean of the College of Nursing and Vice President of Nursing in the hospital from 1972–1987. The practitioner–teacher role evolved from the unification of service and practice to focus on the full professional nursing model integrating practice, education, research and consultation (Christman 1979). In this model, professional nursing practice for faculty and nurses in hospital leadership positions incorporated clinical practice, teaching, consultation and research responsibilities. Termed the unification model, all nursing positions encompassed these role responsibilities; however, the way in which the different components were fulfilled differed. Master's prepared practitioner–teachers often concentrated on clinical practice, staff development and clinical education of students, while doctorally prepared faculty emphasized graduate and undergraduate education and clinical research (Cochran *et al.* 2000). While doctoral preparation was not

required, today many practitioners are prepared at the doctorate of nursing practice (DNP) or PhD level.

In the original practitioner–teacher model, clinical practice commitments and education were closely linked with a designated service area, often in a unit-based role. Dr. Christman was a strong advocate of the practitioner–teacher model and emphasised that the role was not simply a dual appointment role, but rather an opportunity for full professional nursing development – in which the four major components of service, education, consultation and research are integrated under one administrative umbrella. As implemented at Rush University Medical Center in 1972, the administrative and educational structure that facilitated actualization of the role was essential to the success of the practitioner–teacher model. However, as proponents of this role have taken the model and implemented it in numerous and diverse organisations, the role structure has evolved and runs the gamut from full integration to collaborative arrangements between practice and academic settings. Nursing care continues to improve as new knowledge and the use of new knowledge is furthered by the practice–academic link.

Design

An exploratory literature review on the practitioner–teacher role and practice–academic models was conducted combined with review of practitioner–teacher and practice–academic exemplars. The literature search terms 'practitioner–teacher', 'teacher–practitioner', 'practice–academic partnership', 'academic–practice partnership' and 'practice–academic models' was conducted using Ovid Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, and EBSCOhost for the years 1960–2014 for English referenced citations.

Methods

The authors used a descriptive review of the practitioner–teacher model of nursing practice to identify the activities of the role including clinical nursing care. The components of the role include professional nursing practice, serving as a preceptor for nursing students in a focused area of expertise, consulting on patient care issues, presenting in-services and course lectures, providing seminar activities for staff nurses and nursing students, and serving as a member of faculty and nursing division committees (Christman 1979, Cochran *et al.* 2000, Donaldson & Fralic 2000, Elpern 1997, Stanley *et al.* 2007, Clark 2008).

Configuration of the organizational structure was an essential feature to the development of the practitioner–teacher model. An integrated matrix model for unification of nursing efforts was established to embed faculty into the service and administrative structure (Cochran *et al.* 2000). The model consisted of hospital unit leaders who had both faculty responsibilities as well as clinical oversight for an individual unit, divisional chairpersons who had line authority and accountability for their respective clinical and academic departments, with the dean of the college of nursing sharing higher level administrative oversight for both functions. Hegyvary (1984) noted that organisational structure is a facilitator for collaboration between education and practice. She identified that structure sets the framework for behavior but emphasised that the important part of collaboration is not the form (structure) but the substance which is the ‘practice of nursing and excellence in academia.’

In its original format, the practitioner–teacher was unit based and performed a variety of roles. The specific role aspects were negotiated on an individual basis. For Medicare cost accounting purposes, a formal contract was established that outlined service and educational related responsibilities. Typical practitioner–teachers were reimbursed approximately 25% for academic activities and 75% for their clinical roles.

Several aspects related to the educational structure also helped to facilitate the development and implementation of the practitioner–teacher role. College of Nursing departmental chairs oversaw faculty workloads and negotiated the practitioner–teacher positions on the service side. Roles were established and then re-evaluated on an annual basis and concurrently with faculty appointments and promotions in the college. Faculty communicated and disseminated service-related initiatives to showcase role components in many venues including institutional forums, educational seminars and publications. At the time of development, few unification models existed and Rush’s Unification Model became a widely recognized model for practice–academic partnerships.

Faculty recognized the advantages of the model. ‘A symbiosis between education and practice creates a milieu of professional excellence and constant interchange. Through this, individual faculty members are more likely to achieve self-actualisation as professionals’ (Llewellyn 1985). It was also noted that the collegiality that existed with other disciplines within the medical center was fostered by nurses with advanced preparation and faculty status.

Results

The practitioner–teacher role lends itself to promoting practice–academic partnerships that combine clinical nursing

care with professional nursing activities. While the original practitioner–teacher model was a successful one, several changes within the administrative and fiscal environments of the medical center resulted in changes in the role. Originally, the model enabled each clinical unit to have one or several practitioner–teachers who were unit based. A shared nursing governance model, originally established in 1982 helped to further foster involvement of practitioner–teachers with service-based committees and initiatives. The Professional Nursing Staff self governance model promoted involvement of faculty members in key service-based initiatives such as adopting a new clinical charting format, developing nursing standards of care, devising a peer review process for staff and modification of the nursing care delivery model to include the unit assistant.

Discussion

Several changes in the health care environment occurred which impacted the enactment of the traditional integrated practitioner–teacher role. Changes included movement away from cost-based reimbursement models, a shift of more care outside of the hospital, a health care system that was becoming increasingly complex, and faculty requirements that were escalating. Managing both clinical and academic enterprises became increasingly difficult in a unified administrative structure. The Dean of the College of Nursing and the Chief Nursing Officer delineated role responsibilities that provided more clarity and accountability but separated the two entities. This was a significant change for the model. Although quite necessary for the changing times, many of the advantages found in the original practitioner–teacher model were at risk. However, throughout this transition, the original values of the integration of practice remained strong.

Conclusions

The traditional model of practice, education, consultation and research of the practitioner–teacher position has evolved over the years but it remains a viable model to link practice–academic partnerships. Several clinical units retained a practitioner–teacher but reconfigured the role to focus on administrative and clinical responsibilities. Other units no longer fiscally supported a practitioner–teacher role formally, but continued to have strong informal links with faculty, particularly related to student clinical experiences on the unit.

The medical center received Magnet Recognition status in 2002 reflecting the institution’s emphasis on promoting

professional clinical nursing practice and establishing more emphasis on evidence-based practice through clinical nursing research initiatives. As a result, new formal affiliations of faculty positions for service side responsibilities arose. The practitioner–teacher role encompasses a variety of role activities (See Table 1). The specific role components that are enacted in the practitioner–teacher role vary, depending on specific clinical settings and individual contracted role. Several examples of the reconfigured role include both unit based and service wide involvement (See Table 2).

Today, the unit-based practitioner–teacher role is typically a 0.5 FTE appointment in the medical center and a 0.5 FTE appointment in the College of Nursing. In this role, the practitioner–teacher has teaching responsibilities in coursework and clinical experiences for nursing students in the College while having a significant service-based role in the medical center. Clinical responsibilities include consultation, patient care, nursing education, quality improvement and project support. A key component of the role is ensuring facilitation of evidence-based practice and research at the organizational and unit level to assure integration, which is acknowledged as an essential element in promoting evidence-based practices (Cullen *et al.* 2005). Other models of practice–academic partnerships also highlight the contribution of these arrangements in promoting an infrastructure for generation, dissemination and application of knowledge to improve nursing practice and patient outcomes (Llewellyn 1985, Swan & Evans 2001, Stanley *et al.* 2007, Gerard 2010, Dreher M *et al.* 2001).

As part of the reconfiguration of the practitioner–teacher role, several system wide service roles have also been established. One incorporates two faculty members who serve as co-chairs of the Professional Nursing Staff Research Committee. Over the two years that this role has been in exist-

Table 1 Activities of the practitioner–teacher role that enhance practice–academic partnerships

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- Provide clinical consultation in area of specialization
 - Serve as a clinical resource to staff nurses
 - Facilitate evidence-based practice and implementation of best practices
 - Promote research utilization
 - Involve staff in clinical nursing research
 - Serve as a preceptor for new clinical nurses
 - Provide education to nursing staff
 - Precept undergraduate and graduate nursing students
 - Lecture and course direct undergraduate and graduate nursing courses
 - Facilitate unit-based quality initiatives
 - Serve on unit-based and institutional committees
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Table 2 Examples of practitioner–teacher involvement in clinical activities

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- Service as education-quality coordinators
 - Support and involvement in the Advanced Practice Nurse credentialing process
 - Leading the development of a palliative care program
 - Facilitation of Labor and Delivery project to support women in labor
 - Coordination of the neonatal resuscitation program
 - Development of the ‘Twelve and a Half Minute Inservice’ to keep staff educated
 - Support for quality projects and staff education on the orthopedic unit
 - Support to evaluate new patient care products
 - Support to the Professional Nursing Staff Standards of Care Committee
 - Leadership of the Professional Nursing Staff Research Committee
 - Leadership for the premature breastfeeding program
 - Psychiatric nurse liaison role to provide psychosocial support to patients, families and staff in crisis
 - Authoring of the standard of care for end of life issues
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tence, the number of evidence-based practice and research projects has grown significantly. The practitioner–teachers provide individual and unit-based consultations for projects, institutional review board approval application submission, and research support including study design, data collection and data analysis support. Mentoring to complete poster and paper presentations as well as publications has also been facilitated by the practitioner–teachers in this role. In 2007, the Center for Clinical Research and Scholarship was formed to serve as a formal mechanism to help further advance research and evidence based projects. Two practitioner–teachers serve to mentor clinical staff to develop formal research proposals. Pilot funding is available for clinical teams to propose research ideas. Teams are formed to join clinical staff with a faculty mentor for the project along with a graduate nursing student to facilitate their exposure to the research process. Currently, there are over 30 clinical projects that were facilitated under the direction and assistance of the practitioner–teachers including quality improvement projects, education-based projects, pilot study initiatives and research studies. The center also sponsors clinical grand rounds with internal and invited researchers, applies for and obtains research funding for clinical projects, and facilitates a journal recycling initiative for faculty to donate their monthly journal issues that has resulted in distribution of over 1000 clinical and research journal issues to the clinical units to promote dissemination of research and evidence based practice resources for clinical staff.

Exemplars

The need to base research in current clinical practice is a keystone of the practitioner-teacher model. The practitioner-teacher model has contributed to improving patient care practice and has promoted positive patient outcomes in its focus on joining experienced academic faculty with practicing nurses in clinical care areas to identify clinical improvement projects, opportunities for integrating evidence-based practice through mechanisms such as journal clubs and unit-based quality project, promoting the clinical environment as a laboratory for student and clinician learning and through fostering clinical research.

One of the first practitioner-teachers at Rush, was Dr. Andrea Barsevick, currently Professor & Director of Nursing Research at Fox Chase Cancer Center in Philadelphia. Fox Chase Center has an organisational expectation of nurse involvement in research as a result of Barsevick's leadership and demonstration of the model. Barsevick provides support to RNs involved in conducting evidence-based practice (EBP) through lectures, demonstrations and examples of EBP projects. (A Barsevick, personal communication) Nurses study clinical questions and publish the results. Clinical nursing practice at Fox Chase Center is based on standards of care and the EBP Council members support the conduct of reviews, synthesis and evaluation of literature for topics related to new nursing standards. Additionally, Barsevick receives NIH funding to study clinical questions related to symptoms and toxicities from cancer therapy as well as quality of life issues. (A. Barsevick, pers. comm.).

Other examples of the integration of research and clinical practice can be traced to the presence of former Rush students and employees. Examples such as the work done by Lyder (2006), Tucker *et al.* (2009), Rich (2005), Pelligrini (2009), Roberts *et al.* (2009), Gross *et al.* (2011), Horton-Deutsch *et al.* (2007), Lefaiver *et al.* (2009), Micek (2009), Rivera *et al.* (2008), Bosek *et al.* (2003) and others demonstrate that the relevance of the research increases when it is based in practice questions and thus influences the change in practice to an evidence-based approach.

Graduates of the various RU CON programs have implemented the practitioner-teacher or unification role at their institutions of employment. A recent graduate of the Doctor of Nursing Practice (DNP) program stated

'The Rush University practitioner-teacher model, with faculty engaged in combined roles further prepared me to move into my current role, where the faculty model is one of Unification, linking education, practice, and research. The Rush University DNP program brought my leadership skills to a new level and prepared

me as a 21st century leader in today's challenging healthcare system.My faculty role as Associate Director in the multidisciplinary Leadership in Healthcare Systems masters program includes ensuring that the program prepares next generation healthcare leaders. My joint appointment gives me a window to both practice and education and permits me the opportunity to see how they can shape and influence each other to an even greater degree moving forward.' (M. Unger, personal communication)

Unger's statement illustrates how organizations are realizing the benefit the practitioner-teacher model offers.

Relevance to clinical practice

The practitioner-teacher model has served to optimize the way nursing practice and academic settings work together to integrate knowledge, scholarship, service and learning to advance the profession and the discipline of nursing. The model has been extended to numerous clinical and academic sites throughout the US as faculty, students and clinicians who have moved to other institutions have continued to utilise the model to promote education and clinical partnerships. The professional component of the model is especially evidenced by practitioner-teachers serving in local, regional, national and international professional organisations, further influencing the collaboration among practice, education, research and service.

The practitioner-teacher role is a unique model to link practice-academic partnerships. Reconfigured roles to re-establish formal education and service partnerships have resulted in a strengthening of resource support to the service side as well as clinical practice opportunities for faculty members. Unit-based practitioner-teacher positions as well as hospital wide roles focusing on research and evidence based practice which enhance a Magnet environment have proven successful in enhancing clinical nursing care and patient outcomes. As Hegyvary (1984) noted, the institution must embrace the type of culture change necessary to successfully implement clinical partnerships. Support for the role from both the service side and educational side are essential aspects. The practitioner-teacher model has evolved over the years, but has been retained and remains a unique and successful model for promoting practice-academic partnerships.

Practice academic partnerships

Other examples of practice-academic partnerships have identified several key considerations for forming and sustaining relationships including securing strong adminis-

trative support; establishing consensus on goals and objectives; formulating an implementation plan with sequencing and a timetable of essential tasks; and a clear delineation of responsibilities. (Haw & Ferretti 1995, Seifer *et al.* 1996, Donaldson & Fralic 2000, Hewlett & Bleich 2004, Williams-Barnard *et al.* 2006, Gillis & Fuchs 2007, Stanley *et al.* 2007, Murray 2008).

Additional components for formulating successful models include communication, interdisciplinary team development, program leadership at the highest level of the institution, networking and peer support, and ongoing program evaluation of success in a partnership (Campbell *et al.* 2001, Swan & Evans 2001, Haas *et al.* 2002, Barger & Das 2004, Herrin *et al.* 2006).

International examples of practice-academic partnerships have also emerged. Clark (2008) describes the benefits of partnerships based on the experiences of two institutions in the United Kingdom, including the sharing and pooling of knowledge, expertise and resources, enabling sharing of information, exerting greater influence, improving organizational efficiencies and providing greater opportunities for innovation.

Campbell and Taylor (2000) review models of collaborative practice and advocate for collaboration between academic and clinical nurses as a way of ensuring clinically relevant research in Australia.

Due in part to the increased interest in practice-academic partnerships, the American Association of Nurse Executives (AONE, 2014) has created a toolkit outlining some key principles of academic practice partnerships as well as examples of organization models. Readers may find this toolkit, which can be found at the weblink: <http://www.aacn.nche.edu/leading-initiatives/academic-practice-partnerships/tool-kit>, useful as it provides examples of other organisational models.

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Contributions

Study design: RK, JL, MFC; Data collection and analysis: RK, LC, MFC; Manuscript preparation: RK, JL, MFC, LC, MD.

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