

Beyond closing the gap:  
An evaluation of the lecturer-practitioner role

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## Introduction

In the UK, despite an explicit political agenda with an emphasis on bringing education, practice, research and development together, little empirical research has been undertaken to evaluate the effectiveness of educational roles in practice. The roles of lecturer-practitioners and, increasingly, practice educators, practice teachers and clinical facilitators are described in the literature as focusing on the ‘theory-practice gap’ with a view to enabling students to make links between the theoretical input at Higher Education Institutions and their experience in practice placements. Nevertheless, in the absence of agreed outcome measures, evaluations which aim to explore student experience and the role’s impact on clinical practice have been difficult to carry out. Reasons include their relatively small number, the differences in role definitions across localities and varying levels of authority and responsibility.

Similarly, the role is rendered problematic for post holders as a result of a lack of guidance on how to embed these roles into the organisational structures of both health care providers and universities. Identifying organisational structures that actively support learning in the practice setting and finding ways to manage and maintain joint educational roles are the first building blocks to developing a career path model that integrates practice and education, and similarly research. Such a model to enable, and even encourage, individual practitioners or lecturers to combine practice with education or research could usefully overcome the discontinuities in nursing careers, as presently individuals still face many disincentives and hurdles to integrating or moving between roles. The challenge of such a model is embedding joint educational nursing roles into the organisational structures of both institutions.

The Institute of Health and Community Studies (IHCS) at Bournemouth University has developed a collaborative model of education, practice and research with colleagues in health care. Over the last five years, some 80 lecturer-practitioners have been appointed whose posts are jointly administered and managed by the practice institution and the university. This evaluative study has focused on ten lecturer-practitioners who were working within one practice institution in acute care. During the life-time of this project (2000-2002), 30 practice

educators have been appointed to lead and support pre-registration education in practice in line with national policy (DoH 1999; UKCC 2000). Some lecturer-practitioners are directly involved with the support of pre-registration learners on practice placements, particularly in partner trusts where practice educators have not yet been appointed in sufficient numbers to meet the demands of an increasing student population. However, the majority of lecturer-practitioners both lead and support post-registration education in their practice institution and at the university. Nonetheless, lecturer-practitioners have a significant role in the delivery and development of the pre-registration curriculum, particularly in units of education where they have clinical expertise, e.g. pain management, critical care and care of older people.

### Study aims

The aim of this study was to show the impact of the role, using a case-study approach, focusing on IHCS at Bournemouth University and one of its partner practice institutions (Poole Hospital NHS Trust). The research focused on the personal experiences of lecturer-practitioners and their managers with a view to drawing out common features of the role as well as highlighting important differences. The study also sought to explicitly address and articulate issues of responsibilities in relation to lecturing and practising, which are often left implied rather than made explicit in evaluation studies (Fairbrother & Ford 1998; Wright 2001).

The theory-practice gap in nursing was the major theme emerging from the study. The lecturer-practitioner role was often quoted as an initiative to bridge it. Indeed this 'bridging function' that participants described in their contribution to this study served to refine our understanding of the theory-practice gap to include: the connection that is created through the medium of the lecturer-practitioner role in terms of professional education and professional practice; the organisational link between the practice institution and the university; and the challenge of bringing research evidence into practice.

### Report aims

- To provide a review and discussion of the literature in order to locate this evaluative study in its current context;
- To provide an overview of the methods used to collect and analyse the data gathered for this study;
- To report on the findings of this study;
- To discuss some of the practical and theoretical considerations emerging from the findings.

## Literature review

- Theory-practice gap** In their comprehensive review of the literature, Fairbrother and Ford (1998) explore the needs of service and education provider institutions that shaped the development of the lecturer-practitioner role. They also investigate the role's origins and definitions. They trace its roots to the attempts to reduce the so-called 'theory-practice gap'. This approach to reviewing the literature on lecturer-practitioners has also been adopted by other authors, resulting in a large amount of descriptive literature conceptualising the role as an initiative to integrate theory and practice (Newman et al. 2001). By virtue of the fact that their responsibilities straddle both educational and service institutions, so the argument goes, they are able to provide a link between both institutions, and by implication between theory and practice.
- Research-practice gap** This conceptualisation of the lecturer-practitioner role has become a truism which has done little to move the debate about educational roles in practice which 'bridge the theory-practice gap' towards a sound, theoretically rigorous framework for illuminating their impact in both settings and evaluating their effect. However, recently published literature offers some important insights into this 'bridging activity' that educational roles in practice are purported to engage in. Harvey et al. (2002), Wright (2001), Thompson et al. (2001) and Newman et al. (2001) attend to the relationship between research or evidence on the one hand, and practice on the other, and the role of individuals who are seen to be both clinically and educationally credible for facilitating practitioners' evidence-based decision making. For example, Wright (2001) describes how lecturer-practitioners contribute to evidence-based health care through identifying ways in which practice can be developed in line with relevant evidence by enabling practitioners to access research and establishing multi-professional practice forums. The lecturer-practitioner becomes a 'research interpreter', a proposition which is supported by the work of Thompson et al. (2001) who suggest that the medium through which research evidence finds its way into practice is more likely to be a trusted and credible person, rather than text-based electronic resources.
- LP as mediator and interpreter** Although Newman et al. (2001) comment positively on the use of the evidence-based practice model by lecturer-practitioners and the use of

lecturer-practitioners to promote evidence-based practice, they concede that there is a lack of evidence to support their impact in terms of practice development and lasting improvements in patient care. None of the above authors attends to the contested and problematic nature of the relationship between research and its effect on practice, and what Hammersley (2002) calls the 'false expectations' set up by the engineering model of research emphasising the supply of propositional knowledge and technical solutions. Although Hammersley argues from within the context of education, his point that 'practice cannot be founded on what research produces' (Hammersley 2002; 52) is equally valid in the context of health care practice. The concept of the lecturer-practitioner as mediator and interpreter of research and theory, enabling practitioners to make choices about sources of knowledge of which research is one among several, rather than the only one, is useful when exploring the role of the lecturer-practitioner and the nature of the 'bridging' they are purported to do.

#### Theory-practice gap in nurse education

A better rehearsed argument surrounding the theory-practice gap is the one about students' experience of conflict between the theoretical input in the classroom and 'real nursing' in the practice setting which can lead to them being ill-equipped for working as qualified practitioners. Lecturer-practitioner roles are discussed as a possible solution to 'ensure the fusion of theoretical knowledge and practical experience for students' (Hewison & Wildman, 1996; 747), a claim which has been tested and discussed by Williamson and Webb (2001). The literature provides the following historical insights and developments informing this long-standing debate:

The movement of nurse education into Higher Education Institutions resulted in the demise of the clinical tutor (Martin, 1989). Consequently clinical teaching moved largely into the domain of clinical staff that had usually undertaken a preparatory course in teaching and assessing students (Myrick, 1988). The responsibility to teach future professionals then rested with all nurses in their respective clinical areas (NHS Executive, 1997). However, this placed an enormous burden on clinical staff, who were expected to fulfil their role as teacher and assessor of students against a background of increasing patient acuity and throughput, in addition to the obligation of maintaining their own professional development. This often resulted in limited attention being given to individual students, thus restricting their opportunities to 'learn'



the craft of nursing. Concern was raised over the apparently widening theory-practice gap in nurse education as a result of this move to Higher Education (Mallik, 1993). It was acknowledged that higher order learning did not necessarily lead to competence in practice, and was further exacerbated by the practicalities of clinical staff having limited resources to guide novices through the complexities of practice, resulting in uncritical replicators of existing nursing practice (French, 1996).

## Early LP models

The development of partnerships between education and practice via the implementation of the lecturer-practitioner role, as first developed in Oxford (Fitzgerald, 1989), was proposed as a strategy for facilitating student learning and closing this theory-practice gap. Its implementation across the UK was inconsistent (Hollingsworth, 1997). This has led to difficulties in providing consistent definitions for the role which are seen as fundamental for meaningful evaluations (Lathlean 1995). Bond and Thomas (1991) noted that research that concentrates on outcomes, and where structures and processes are left assumed and undefined, makes it impossible to link outcomes, favourable or unfavourable, to specific features of input. Many comment that the lecturer-practitioner role is ill-defined (Davis, 1989; Woodrow, 1994; Stitt, 1995; Fairbrother & Ford, 1997). However, this is not altogether surprising as Jones (1996) and Hollingsworth (1997) both report in their respective surveys that each post is multifaceted, complex and unique, and implemented in different ways depending on local needs. Elcock (1998) applies Rodger's (1993) evolutionary concept analysis in an attempt to identify and clarify those elements common to the concept of the lecturer-practitioner. She concludes that, despite the multifaceted nature of the concept, the role has common attributes, antecedents and consequences, that it describes a person who is an important link between nurse education and service, and that it is a role that will continue to evolve. In an attempt to move towards a shared understanding, Vaughan (1990) describes lecturer-practitioners as having responsibility and authority for both practice and education within a defined clinical area, with two broad but clearly defined aims which were later adopted by the English National Board (1996):

- To identify and maintain the standards of practice and policies within a defined clinical area;
- To prepare and contribute to the educational programme of learners in relation to the theory and practice in that practice area.

This definition provides a broad, non-prescriptive description of the lecturer-practitioner role. This flexibility is important as the potential success of this role depends to a large extent on their ability to meet local needs by being context-specific and individually focused to their particular practice area (Martin 1995; Jones, 1996).

## Role evaluation

Fairbrother and Ford (1998) provide a comprehensive review of the multifaceted aspects of the lecturer-practitioner role. They focus on the need for lecturer-practitioners, their origin, the development of their role, and the debate surrounding maintenance of academic and clinical credibility. In conclusion, they make a positivist claim that no systematic objective evaluation or empirical research of the role has been undertaken. There is certainly abundant theoretical and anecdotal justification for the role in what can be described as reflective comment papers (Burke, 1993; Dearmun, 1993; Childs, 1995; Martin, 1995; Neill & Muir, 1997; Jackson, 1999; McGowan, 1999/2000; Humphries et al., 2000). The authors of this non-evaluative literature are highly supportive of the role. They assert that the lecturer-practitioner helps to create a positive learning environment for students in clinical placement areas, makes a difference to the issue of recruitment and retention of staff, and helps to close the theory-practice gap.

This literature review demonstrates that two epistemological bases are being expounded. Positivist researchers have been concerned with the question 'What are the multifaceted aspects of the lecturer-practitioner role?' (NHS Executive, 1997). This commissioned study consisted of a postal survey to Trusts throughout England with the objective of collating information regarding details of employment of lecturer-practitioners. A total of 398 questionnaires were sent out of which 303 were returned giving a good response rate of 70%. However, the validity of its findings may be challenged as only just under half of the Trusts who returned questionnaires (42%) had lecturer-practitioner posts. This raises the question as to whether the remainder were in a position to comment on the role. Measurement is simply a means of categorising observations into a form for mathematical manipulation. These procedures involve information loss and reduction and the fact that approximately half of the respondents were not in a position to provide answers to such a questionnaire cast doubt on the data generated by this survey. Mathematical data is no guarantee of validity (Hiles, 1999). It is, however, interesting to note that in the slightly earlier survey by Jones

(1996), lecturer-practitioners did not explicitly see part of their role as bridging the theory-practice gap. Yet this survey (NHS Executive, 1997) and managers in both service and education saw closure of the theory-practice gap as a key role. This apparently evolutionary change may reflect the Labour Governments' political agenda for the NHS (DoH, 1997).

Reasons for the development of the role

Others have conducted positivist studies to examine how lecturer-practitioner posts were being set up and supported (Jones, 1996; Fairbrother & Ford, 1997). Data were collected through questionnaires and/or structured interviews with senior nurse managers, senior staff in higher education and lecturer-practitioners themselves. These studies established common principles for developing such posts, how they were arranged, the problems experienced by those in lecturer-practitioner posts, or those involved with supporting such posts, and made recommendations for the successful implementation of lecturer-practitioner posts. These papers together with the NHS Executive (1997) survey agree that the reasons for establishing lecturer-practitioner posts are to promote effective collaboration between service and education, promote research-based practice, develop nursing practice and facilitate the application of theory to practice. However, these studies do not focus on the impact made by the lecturer-practitioner role on the attainment of enhanced student learning and subsequent improved quality of patient care. The ultimate success of the lecturer-practitioner role will be in showing that the health status of communities and the quality of life of patients have improved as a result of improved student learning and staff development.

Effectiveness and value

Rowan & Barber (2000) examine the effectiveness of the lecturer-practitioner role by asking the question 'Does the lecturer-practitioner role improve the quality of student clinical placements?' These authors sought to evaluate their own role by issuing questionnaires to their own students, ward staff and college tutors. They concluded that the statistical data generated by their questionnaires showed an agreement that this role strengthened the partnership between education and service. However, doubt may be cast over the validity of this finding as these researchers were evaluating their own effectiveness in a situation where they would conceivably have had some impact on their own findings through their conduct, manner and relationships with their respondents. Perceptions and expectations of choice, particularly of

learners, it could be argued, are constructed over time in relation to the views of tutors, peers and practice partners, in what could be described as the 'school effect' or the institutional habitus.

Driver and Campbell (2000) attempted to evaluate whether diploma students recognised a difference in classroom teaching between lecturer-practitioner and university-based senior lecturers. Like Rowan and Barber (2000) the authors and researchers are lecturer-practitioners and again no detail is available regarding the information given to the students about the aims and objectives of the research study. The researchers used a statement questionnaire with Likert scales. They chose statements they thought reflected the lecturer-practitioner post closely, for example, 'On reflection my level of knowledge and competence has improved as a result of the learning undertaken.' No information is given as to how these statements were verified as being 'closely' reflective of the lecturer-practitioner role. It is implicit that the goal of any teacher should be to facilitate the development of knowledge. It is also suggested that the use of scales is inappropriate for the investigation of student experience. Such scales fail to establish any knowledge of student situational meaning construction or a comprehensive understanding of student needs. Furthermore, it could be argued that increased credibility in a classroom does not lead to enhanced competence in practice.

Positivists are concerned to isolate causal relationships that are believed to underpin social reality. However, social context determines the exact nature of a role and a one-off score in a questionnaire, for example, does not take account of the dynamic nature of the learning or patient care experience. Structured procedures, such as structured questionnaires and outcome markers, are used to create an objective setting for research and indirectly play a dominant role in such a setting. Although attempts are made to reduce difficulties of wording and meaning by piloting questionnaires, the reliability of research data taken out of its natural context is open to challenge. Measurement that focuses on outcome lacks explanatory power. Such procedures, as Hammersley (1992: 32) points out '...ride roughshod over the complexity of the social world.' Questionnaires offer little opportunity for the respondent to make their response understandable to the researcher. Respondents can only answer questionnaire surveys on the basis of the choices that they believe are available presented through the structure of the questionnaire. It could be

argued that the lecturer-practitioner role does not preclude evaluation, but requires careful contextualisation to aid transferability and applicability of research findings. Quality patient care is located within a matrix of influences, such as individual culture and values, social, institution, family and technology influences.

The relative weight of these spheres of influence is not only different for different individuals, but will shift and change over time along the health/illness continuum. Yet, in spite of the inevitable overlap and blurring of boundaries between these influences, positivists may argue that there are specific markers which could be examined. Caring for the people in health and illness is inherently uncertain and there is an art as well as a science in delivering care that is needed by the individual. This stance supports the view that the positivist paradigm in the context of healthcare, particularly nursing, could be criticised for its simplification because it is limited by its concentration on measurable parameters that ignore the qualitative dimension of both education for practice and caring. Positivist explanations may historically have a superior appearance, but often lack relevance. It is contended that the concept of causation is often quite imprecise, as education for practice and caring often involve multiple factors as well as many that are unknown. As discussed earlier, the difficulties associated with the lack of standardisation of the role, role performance and role ambiguity further compound this issue.

The complexity of the lecturer-practitioner role and its effects are rooted in the social, situational and biographical domain and may be lost in the process of quantification. Representation of reality is achieved by immersion of the researcher in the social milieu being examined (Porter, 1993). The literature review revealed a small number of subjectivist research studies on the role of the lecturer-practitioner (Lathlean 1996; Shepherd et al. 1999; Aston et al. 2000; Dearman 2000). This literature review will now focus on a detailed discussion of these studies.

**Qualitative evaluations** Lathlean (1996) initially intended to evaluate the effectiveness of the lecturer-practitioner role. However, during her preparation for the study, she reached the conclusion first that the lecturer-practitioner role could only be truly evaluated after the job itself was understood and had settled down. She abandoned her original plan and undertook a longitudinal ethnographic study on the implementation and development of the

lecturer-practitioner role from 1989 to 1992. All six lecturer-practitioners identified responsibilities for clinical practice, education, research and management as part of their designated role. In her survey almost all post holders had to cover education and practice, only three-quarters had a research function and two-thirds had management responsibilities. As highlighted by Fairbrother and Ford (1996), this variance in specific roles is perhaps to be expected, as the lecturer-practitioner role is context specific. It is suggested that the apparent gaps and rough edges in the seams of the concept of the lecturer-practitioner do not vitiate its value. However, research is required that attempts to evaluate the effectiveness of the lecturer-practitioner role while at the same time, maintaining sensitivity to the complexity of the role, its effects and its context in a variety of healthcare arenas.

Shepherd et al. (1999) examined the lecturer-practitioners' perspectives of their role in the community using case study methodology. Data were collected using 'conversational style' semi-structured interviews. Conversational style interviews are well suited to the exploration of attitudes, values, beliefs and motives and are valuable as a method of discovery and exploration of new and complex areas. The sample consisted of a purposive sample of four lecturer-practitioners and one community nurse teacher. The researcher-participant relationship, that is a university lecturer evaluating lecturer-practitioner at the same department, is not acknowledged by the authors. It is likely that the researchers approached the task with a set of preconceptions and experiences that may have influenced the way the experience was described by the respondent and the way the data were collected and analysed. There is no evidence of researcher reflexivity, that is, a conscious self-understanding of the research process.

Rigour is enhanced in subjectivist research by explicating the personal, and exposing the vulnerability, attributes and beliefs of the researcher. It could be argued that in this situation the respondents might have many identities that may have been donned, shed, muted or made salient as a result of the interview environment. However, the authors do state their use of single interviews to be a limitation of the study as it precluded the researcher in evaluating the truthfulness and hence credibility of the respondent's answers. The authors claim that because of this, truthfulness and consistency were checked through observational data, although no details regarding this are given. The five respondents' 'time

in post' at time of interview are given as between six months and four years. It is suggested by the researchers that to interview anyone in such a complex post after only six months may invalidate the data, especially where such a small sample of lecturer-practitioners was used (n = 4). The following themes were identified: liaison role, student preparation for clinical practice, and relating theory to practice.

Aston et al. (2000) conducted a case study commissioned by the ENB to examine the role and qualities of the lecturer-practitioner in adult nursing practice. The researchers used individual and focus group interviews with lecturers (n = 76), practitioners (n = 46) and students (n = 131) in five schools of nursing. The researchers followed an interview schedule of pre-determined themes which were as follows: role preparation, transition and development; the context of support; the nature of the practice role; qualities needed; measuring effectiveness; alternatives and reflections; value perceptions. Here the researchers directed interviews by constructing questions around identified dimensions and set an agenda that they, the researchers, consider important. It could be argued that this approach may have given respondents little or no independent input. Aston et al.'s study (2000) reveals the challenge the evaluation of this role presents to researchers.

Dearman (2000) examined the potential contribution of the lecturer-practitioner in offering professional support to children's nurses within one year of qualifying. She conducted in-depth interactive interviews with ten nurses on four different occasions during their first year of qualifying. Dearman found that students experienced a mis-match between support offered and support they perceived they required and concluded that lecturer-practitioners may generate optimal conditions to nurture professional development and retention. However, Dearman does not state her relationship with those students she interviewed, that is, whether she had pastoral or teaching responsibilities for the students in her position as principal lecturer at her University. In addition, no information is given on her sample selection or access. As qualitative research is inherently an interpretive process, any personal connections the researcher has with the participants need to be articulated together with personal experiences, perspectives and assumptions.

## Conclusion

There appears to be a consensus in the literature that lecturer-practitioners do have an important role to play in bridging theory and

practice and in addressing the mis-match between what is taught in the classroom and what is experienced by students in practice. Similarly, they have an important role to play in facilitating the practitioners' decision-making in ways that make it congruent with relevant research findings. Such claims in the literature are usually accompanied by the implication that this in turn enhances patient care.

The literature also indicates that lecturer-practitioners bring an enormous potential to improve nursing and midwifery education and practice. Advancing nurse education in the UK means building on the legacy of the past, capitalising on existent knowledge, experience and technologies and integrating these with a vision for the modernisation of the NHS workforce.

However, to date, the value of the role has not been convincingly demonstrated. There is a dearth of empirical evidence that looks at the effectiveness of the lecturer-practitioner role, and as a result individuals themselves and their managers may face problems in identifying the best way to develop such posts. In addition, the setting of performance objectives for post holders can also be problematic. Benefits of such a role are not easily quantifiable, and qualitative evaluation of role effectiveness is argued to be more appropriate. Studies currently available (Jones, 1996; Lathlean 1996; NHS Executive, 1997; Shepherd et al. 1999; Aston et al. 2000; Dearman 2000; Williamson & Webb 2001) demonstrate that the lecturer-practitioner role is complex and requires a considerable array of skills. Lecturer-practitioners themselves and their service and education managers are in the best position to identify the potential impact of the role on the development of practice.

Research attempting to articulate and evaluate this role is increasingly pressing because a key part of clinical governance is the need for a systematic approach to the development of continuing professional development and educational roles within organisations. In order to achieve this, organisations need information on the nature, scope and process of this role. However, such information is only meaningful if there is conceptual and theoretical clarity. This research project seeks to illuminate this, as yet, little explored area.



## Methods

The research strategy adopted for this project was a case study, which has been described by Yin (1992) as a strategy for doing research involving an empirical investigation of a particular, contemporary phenomenon within its real life context using multiple sources of evidence. The aim of this particular case study was to provide an in-depth description of the role of lecturer-practitioners through generating and analysing qualitative data. This would assist in the identification of salient factors in the local context and history of the role. As a result, it was anticipated that theoretical implications could be deduced which would inform the development of an evaluative framework for the lecturer-practitioner role.

The 'case' was a group of 10 lecturer-practitioners employed by one health care provider, an acute care trust in the South of England linked to the Institute of Health and Community Studies at Bournemouth University. Sources of evidence included open and survey interviews with two distinct groups of participants connected with the two organisations, as well as documents relating to the lecturer-practitioner role. All 10 lecturer-practitioners were interviewed with a view to obtaining narratives of their experience of being a lecturer-practitioner. Survey interviews were conducted with 17 stakeholders who offered managerial overview or who had a strategic role in planning education at the university or the health care provider institution. Lecturer-practitioners were also invited to submit job descriptions for documentary analysis.

## Data collection

### Lecturer-practitioner interviews

The post holders covered the following areas:

- Critical care;
- Oncology;
- Nutrition;
- Pain management;
- Neonatal intensive care;
- Midwifery;
- Medicine/Elderly care.

The post holders were made aware of the study through the LP newsletter, which is published at the university, and were subsequently invited to participate by letter. All those invited agreed to take part. Three members of the research team carried out the individual interviews, two of whom were known to the participants through collegiate, but not management relationships. The allocation of researcher to participant was random. There was no interview schedule. The researchers involvement in the interview was asking the initial question 'Please could you tell me about your experience of being an LP', seeking clarification and checking their understanding of what the participant said, or asking the participant to expand on issues they raised. The interviews were tape recorded and transcribed.

### Manager interviews

The following groups of managers were identified in relation to the LP post holders:

- Those who had line management responsibilities and whose overall responsibility was the general management of a clinical directorate;
- Senior nurses who either had line management responsibilities for the LP post holders or worked in a peer relationship with them;
- Senior managers at the service provider institution and the university with a remit in practice education and development.

All managers were sent a letter, inviting them to be interviewed as part of the study. The interview was structured around the following questions which the managers received with the invitation to participate:

- How does the educational role (for example lecturer-practitioner) fit into your directorate/organisation?
- In your view, what is the relationship between professional education and service delivery?
- Has the role had an impact on your 'business planning' in terms of resourcing educational activities or changes in service delivery?
- What are your aspirations for developing educational roles in practice in your directorate/organisation?

Three members of the research team carried out the individual interviews with the managers. The allocation of researcher to participant was arranged to avoid members of the research team interviewing previous or current managers. The interviews were tape recorded, then two members of the research team listened to the tapes, transcribed some important sections and summarised other key points made.

**Ethical considerations** All members of the research team complied with the ethical code of conduct for research studies at Bournemouth University, protecting the anonymity of the source of their data and using all information only for the purposes of this study. Written consent was obtained from all participants immediately prior to the interview following an explanation of the research process. Participants were made aware that they could withdraw their consent at any time during or after the interview. They were also reminded of their right to stop the interview if they felt distressed or for any other reason.

All transcripts were typed up within ten working days and sent to the participants for confirmation that they were a true record of the interview. None of the participants made changes to the transcripts.

**Data analysis** Analysis of the two sets of data was carried out separately in order to obtain the two perspectives on the role. The process for analysing the data was cyclical and interactive so that data collection and data analysis occurred simultaneously. Data analysis was informed by Burnard's (1991) method for analysing transcripts in qualitative research. The steps in the process, adapted from Holloway and Wheeler (1996), are summarised below:

- The interviews were transcribed by an administrative support worker and checked by the interviewer.
- Three members of the research team listened to the interview tapes and read the transcripts.
- First notes on significant items by the researchers were collected and shared.
- The collected material was ordered and organised using the 'cut-and-paste' facility in Microsoft Word.
- The data was then broken down and collapsed through coding. Coding was compared, discussed and altered by the researchers, which led to the recognition of initial patterns and recurring regularities.
- Data was further reduced through categorisation, data organisation and data interpretation which was done collaboratively by the research team.
- The research team built, compared and contrasted categories, looking for consistent patterns of meanings, searching for relationships and grouping categories together. The patterns and themes identified are shown in the following sections.

## Findings

### The post holders' perspective

The central theme of the study from the post holders' perspective was the way in which successful lecturer-practitioners were able to negotiate the range of challenges and expectations with which this new role presented them. They addressed these demands which arose out of the 'bridging function' of this role through their own highly developed interpersonal and facilitation skills while effectively operating within two organisations: the university and their workplace in clinical practice. Although individuals' roles had been carefully planned, frustrations with the way individual posts had been put into operation were voiced. Organisational problems were partly explained by the pragmatic response to policy and educational demands the implementation of the lecturer-practitioner role in nursing represents, partly by the diversity of the contexts in which the role has been realised, and partly by the unrealistic expectations of this new role by post holders themselves, their peers and managers.

All post holders experienced their role in a very positive and fulfilling way. However, they also found that existing management structures in both organisations were often not flexible enough to accommodate their needs in carrying out their responsibilities. They also commented on some lack of trust by managers and colleagues in the way they managed their time and their priorities. 'Emotional intelligence' was a crucial attribute which enabled post holders to manage negotiations between conflicting agendas and expectations, to clearly articulate problems and formulate solutions, and to manage ambiguity and uncertainty without becoming de-motivated.

The post holders who were all based within one trust were aware of the diversity of their roles, which originated in the specific needs of the different clinical areas when the roles were negotiated or appointments were made. They were keen for such diversity to be maintained, rather than have a standardised model of working imposed on their practice. However, they welcomed the idea of a loose organisational framework that would help them manage workload and time, and provide specific support for practice development and formal teaching at the university.

The post holders identified concerns that resulted from the dual demands of their roles within broader considerations of preparation for the role, role performance and personal support. The study participants' narratives tended to be structured around these broad themes which are described and analysed in detail in this chapter. Table 1 summarises the aspects of the lecturer-practitioner role which defined it from the post holders' point of view, and contributed to its successful implementation in different practice settings.

Practice dimension	University dimension	Personal skills
Clarity of the purpose of LP role within the department and the organisation.	Clarity of the purpose of LP role within the university department and the institution.	<ul style="list-style-type: none"> <li>• Expert clinical practitioner.</li> <li>• Leadership skills.</li> <li>• Ability to act with 'emotional intelligence'.</li> <li>• Political acumen.</li> <li>• Ability to manage uncertainty and ambiguity without becoming demotivated.</li> <li>• Ability to identify and act on educational aspects of practice development initiatives.</li> </ul>
Understanding and valuing of the role by work colleagues.	Understanding and valuing of role by teaching staff.	
Work-based teaching.	University-based teaching.	
Getting evidence into practice and facilitating change.	Developing as a teacher and as an academic.	
Practice and service improvement through developing individual practitioners and teams.	Informing curriculum content and development.	

**Table 1: Aspects of the lecturer-practitioner role**

Preparation for the role

The majority of post holders were recruited directly from clinical practice, predominantly in specialist clinical areas like, for example, intensive care, pain management and nutrition. However, there were also 'generalist' posts in midwifery and child health.

Participants saw expertise within the practice element of their role as a fundamental requirement for the lecturer-practitioner role, whereas they considered it legitimate to develop skills in the academic setting over time. The skills they considered to be 'educational' included facilitating seminars and action learning groups, delivering mass lectures, marking students' work, contributing to curriculum development and collating

resources for students. Some lecturer-practitioner posts had been specifically developed to meet demands in clinical practice like, for example, educational preparation for practitioners in critical and high-dependency care. This required post holders to assist in the design of programmes in work based education and manage students' clinical learning which, in turn, required personal motivation and the support of management and academic staff.

Reasons for taking up the lecturer-practitioner post included an interest in teaching and learning, practitioners' professional and personal development, practice development and service improvement within their place of work. However, previous experience within a formal teaching role, apart from mentoring and assessing students in practice, was rare. All post holders recognised the importance of a formal teaching qualification although only a small minority had obtained one. The majority of post holders were either undertaking the post-graduate diploma in post-compulsory education, or were planning to start it in the following academic year.

The university-based aspect of their role generated some anxiety and frustration for newcomers, as the interview excerpts below demonstrate:

*It was a sort of a very steep learning curve. To suddenly become a lecturer is quite an onerous title. Expectations are quite high. (LP7)*

*When I'm at the hospital I'm still a Sister. But when I started as an LP, I thought things could happen quite quickly, and of course they don't. And I think that's a big change for me, coming from a clinical area to something like this. I really underestimated how long it takes, just to organise a course and to get all the background documents that you need, get everything written, let alone preparing for teaching sessions. So I've underestimated that. (...) My first year in the job actually took a lot of my own time. (LP8)*

The majority of post holders had previously been in clinical leadership or management positions. Many identified this experience as essential preparation for their role as LPs.

*I do think you have to be experienced at a senior level because, for a start, then you will have experience with management, time management, managing staff, managing people etc, which is very important. (LP8)*

*It's very valuable to have some senior experience, whether that's as an F grade or a G grade... (LP5)*

*I honestly don't think you could do this role without having been a Sister first. I think it would be very difficult to have an understanding of the dynamics of your team and the people you work with if you've not got to that level. (...) You have to have a strong person in this sort of post who can actually say to managers and senior nurses "Well, you know, that isn't the best way, maybe this way's better". I think, to actually be an effective LP you need to be somebody who's had a management role, or been at senior level, actually to take on an independent role in the sense of being able to communicate where you are in your stance and not just be a 'yes' person. And I think it's really important that we're not, because, if you think about being in an area where you need to change practice, if everyone's going to say "no" to you and you're going to go "OK then", you're not really fulfilling your job. (LP8)*

The period of role transition from clinical leadership demanded a clear focus on the part of the post holders to let go of previous responsibilities and develop their new role.

*I think probably the mistake I made was being a Sister in the same unit as I was a lecturer practitioner, or being a lecturer practitioner in the same unit as being a Sister, because one day you are that person. All you did was change your badge. Nothing else changed about you. You almost needed a period of orientation again to sort of almost like re-launch yourself. (...) So that took a bit of time to re-educate people as to what I was doing and why. (LP1)*

Participants also gave examples of other skills and attitudes they considered to be pre-requisites for the role.

*Time management is essential, absolutely essential, you've got to be organised, and you've got to be committed. (LP3)*

*You definitely need a sense of humour. I think you need to be a competent practitioner in which ever area you are working which gives you credibility from your peer group and from students. (LP4)*

*You have to be able to justify your role to different people. You have to be very secure in your knowledge of your own role to be able to do that. (LP 7)*

## Role performance

The participants identified six elements of their role which they needed to balance in order function effectively. They are: visibility, clinical credibility, teaching in clinical practice, facilitating change in clinical practice, developing as a lecturer, and 'emotional intelligence'.

### Visibility

Lecturer-practitioners struggled with being seen and noticed by colleagues in the workplace as the following interview excerpts indicate.

*And you just start to think, OK, you know, how do you make yourself visible? (LP7)*

*However, you still get, when you're in the clinical area, "Oh, here comes the part-timer". (LP1)*

*The pressures are the business of having to be visible, having lots of balls in the air. (LP8)*

*But obviously because I can't be actual hands-on, I mean they just think, "Oh yes, she's got an easy life. She keeps wandering up and down the wards". (LP4)*

On one level they were concerned that although they worked five days a week, one or two of those days were spent at the university. To their clinical colleagues they may have simply been absent and unavailable to deal with operational problems. At another level, 'being visible' may also be linked to 'being valuable' insofar as clinical staff appeared to attach value to having a clinical workload. Without a clinical workload,



the lecturer-practitioner was ‘wafting around’ and had to re-gain her visibility and value in the eyes of her clinical colleagues in a new role:

*They [clinical colleagues] realised then I was wafting around in my supernumerary status instead of being one of numbers.*

(LP8)

However, lecturer-practitioners also felt that there was the risk of university-based lecturers underestimating their clinical work, or expecting what lecturer-practitioners considered to be an unrealistic contribution to activities such as teaching and marking.

*Lecturers who work full-time at the university, I think, probably forget a little bit the clinical side and seem to think that, as an LP, you’re actually a bit of a part-time lecturer and therefore you’re a bit part-time, and probably don’t work as hard as they do. Whereas, in fact, they’re forgetting that you’re working very hard clinically still. I mean there haven’t been any huge problems with that but it’s just sort of some of the vibes that you get sometimes.* (LP3)

### Clinical credibility

Lecturer-practitioners felt strongly about the students’ need to have confidence in those who teach them, not only to know the reality of practice, but to be immersed in that practice. They saw clinical credibility as their unique contribution to the educational processes in which they were involved.

*If you’re going to teach how to look after an intensive care patient, you ought to be able to do it yourself. So I really do think it is extremely important that you are clinically skilled and up-to-date.* (LP8)

However, few commented on the relationship between their clinical credibility and their style of teaching or on how their clinical credibility assisted students to mediate between theoretical and practice based learning. There was an unexamined assumption that this relationship existed and positively influenced students’ learning.

Lecturer-practitioners highly valued their clinical credibility as it was also their greatest source of confidence when teaching in a formal university setting.

*It's the credibility as well, isn't it, when you are stood up in front of a class of students and you know what you've talked about is true because you've been there practising in that manner and doing that procedure with them. (LP7)*

### Teaching in clinical practice

Lecturer-practitioners frequently asserted that, by virtue of the fact that they taught students in both the educational and practice settings, they were able to bridge the theory-practice gap:

*When they [students] are being lectured at the university by the same people that they meet clinically who have time with them in the clinical area to help their learning then its really bridging the theory practice gap. I really think it's the way forward. (LP3)*

The mechanism of this taken-for-granted process was not addressed. However, there appears to be an implicit assumption that the bridging activity consists of helping students in the application of theoretical or propositional knowledge to the practice context. Claims were also made about the use of reflection in both settings to link learning back and forth between theory and practice. Such an understanding moves beyond the one-way model of conceptualising the bridge between theory-practice which assumes that it consists simply of applying theory to practice, rather than of a cyclical or synergistic relationship and an increasing mindfulness of that relationship.

Some lecturer-practitioners articulated what they were doing when they were teaching in clinical practice. The following excerpt illustrates the complexity of what is involved:

*A lot of it [teaching] is by example. (...) You work with some of the junior nurses, you ask them what their issues are, again, because you need to have somebody who's actually experienced nursing at all levels, who has actually had to work through and identify their own problems, i.e. time management. So they can*

*actually share that with someone. And so you can actually go in and, you know, they might identify that time management is a problem. So you then suggest some strategies to try and resolve the problem. I'll give you a really good example. I went to work with this nurse for the day and he said to me that time management was a real problem for him. He was just finding it really difficult to get everything done in his day and he was still doing his documentation at 5 o'clock. And I asked him how he worked all the day, you know, how he's managed to organise his patients with the other people in his team. I didn't tell him or give him any advice about what to do. I just questioned him and asked him why he did certain things in certain ways, and we went through lots of different things. I asked him how he could maybe plan who works with whom differently in his team. I asked him how he could organise things differently and he worked through it all. We had a really good shift and we all went home on time. And I saw him it must have been a week later and he said to me "I don't think I did have a time management problem. It's obvious I just had a bad couple of days because it's been fine since." And it was nice in one way because obviously, a change had occurred, but you couldn't actually, he didn't quite identify that he'd changed that day, that his thought patterns about what he was doing were different and he was actually thinking differently about how he was organising his work. But then, to me, that's what it's about. It's about going in and just helping them change their thought patterns and making them look at what they do. I don't believe a lecturer-practitioner's there to tell people how to practice. You're more of a coach, I think, more there sort of trying to prompt them to think about the things themselves. (LP5)*

This 'teaching' activity, or 'coaching' as this lecturer-practitioner puts it, is about enabling practitioners to re-appraise their practice, sometimes at a level, such as in this case, that is not actually seen as 'learning' and 'changing'. It appears from this excerpt that teaching in clinical practice is more about asking the right questions than giving answers.

Furthermore, the activity of teaching was not seen to be exclusively the territory of lecturer-practitioners, but enabling others to develop the skills, abilities and capacity to support learning in practice:

*I'm not seen as a glorified clinical tutor. I'm there to facilitate others to teach. (LP10)*

Lecturer-practitioners therefore saw themselves as instrumental in creating environments and teams that support learners. Those who worked in specialist clinical areas also assumed an important role in the development and articulation of expert knowledge to be shared within the team of practitioners and students.

### Facilitating change in clinical practice

Lecturer-practitioners discussed the important contributions they make to challenging existing practice and collaborating with colleagues to develop improved ways of working. They expressed their concerns about how to best link insights from theory or research to how things are done in their work place. At issue was often not their clinical expertise or their knowledge about how things work and could work, but how to engage colleagues:

*And some of these [midwives who have been qualified for many years] are in quite senior positions. They're working alongside students who are coming out with degrees and who have these skills [research appraisal skills] and, unless they've sort of gone on to do their own, you know, diploma or degree themselves, they may be feeling a little left behind. So I'm very conscious as a lecturer practitioner on how I can support them, without them losing face, you know, without them feeling that they are out of their depth, you know, doing it in a way that, well, let's work together on this, and so that they are up to speed and don't feel threatened. Because change can be incredibly threatening and I think a lot of people, unless change is handled well, people just retaliate and don't want to have anything to do with it, which is such a shame. Because I think, if you support them in a very positive way and get them involved and give them, you know, the support and skills that tells them "you can do this". Then, you know, you're bound to succeed, rather than almost belittling them which sometimes, I'm afraid, can happen. (LP6)*

This excerpt speaks of an awareness of the process of managing change and the role emotion, self-esteem and collaboration have for individual practitioners who have not been given, or not chosen, the opportunity to

develop intellectual skills. Furthermore, lecturer-practitioners did not see themselves as ‘hero-innovators’, but as critical peers:

*People need to do things in practice, they need to be thinking themselves, they need to be questioning what they’re doing themselves. (LP10)*

Post holders were aware of the benefits of their contribution to the department and the organisation in terms of improvements in the recruitment and retention of staff through work-based education. Much of the material developed by lecturer-practitioners centred on the achievement of competence and the acquisition of relevant underpinning knowledge.

*So it’s commitment, it’s commitment to education. And we’ve seen that the commitment to education is valued very highly, particularly as word gets round. It is improving our recruitment. It’s also improving our retention of staff because they know they’ll get trained. In the long term and in the whole global picture of the hospital, that’s very helpful. (LP3)*

### Developing as a lecturer

There was great variance in the level of competence and confidence which lecturer-practitioners described in relation to performing their formal teaching role at the university. Those who had been in post for over two to three years had completed their teaching qualification and had gained experience in using a variety of strategies. Others drew on a variety of sources: their own experience of higher education as students, reading about methods in teaching and learning, attending staff development sessions at the university, being mentored by a lecturer or tutor, and seeking advice from their subject team. The following excerpts reveal the range of strategies which lecturer-practitioners adopted in order to develop as lecturers and academic educators:

*I’m learning all the time and getting feedback from people all the time. You have to be willing to take feedback and I value my students’ feedback very, very highly and I say to them “If something doesn’t work well you’ve got to tell me” or “If you don’t like the way we do something, you’ve got to tell me,” because I’m learning all the time. (LP3)*

*Every time I do prepare a teaching session of course I make sure that I'm reading up-to-date articles, journals etc. (LP7)*

*If you've worked the weekend, and you've had a really bad time, you've got a late on Sunday you're in class with them [students] on Monday morning, you feel tired and you think "oh, no", and you look at them and you think, "well, they don't look any better" (laughs). You know, you pick it up from them, don't you? So you might start off with a coffee first of all and, you know, sort of say, "What have you been doing over the weekend?" And if they've had an interesting patient, you might just sort of have a look at that more. Almost like a bit of a counselling session sometimes because obviously, you know, critical care, the nature of things happen extremely quickly and they might need a bit of debriefing before they can go on to whatever you're meant to be doing. But, you know, they always fulfil your objectives for that day and you have that flexibility with them that if you're running late, you know, they might only have sort of 10 or 20 minutes lunchtime instead of the hour because as nurses they're not used to having a whole hour. And you might run later in the afternoon, and like with tutorials and things, you know, you've got that flexibility to give them time. Or you could just pick up the phone and have a quick chat because you've developed a rapport working with them clinically that you would not have if you had students just coming in cold. (LP8)*

*Yes, the work load is enormous but, in order to develop the education to actually write open learning for instance, there is some time that you have to take out to educate yourself in order to educate others and that's quite powerful because then that gives you the ammunition to drive change and allows you to step back and really change the system. (LP10)*

They valued their role at the university and in the workplace insofar as they felt they were able to make judgements on the relevance of theoretical material and inform curriculum development:

*It's good to have the dual role so you can really see both sides. And you can see that if you think the students need to learn*

*something, because you recognise that in the clinical area, you can then take that forward to the university and make sure that it happens in the way that you think it ought to happen. (LP1)*

*From a clinical point of view it's really good to know how the students are learning at the university. When you're not teaching, it's very easy to think, oh, the university should be teaching this and it should be teaching that. So it's very good, I think, to have the dual role so you can really see both sides. And you can see that if you think the students need to learn something, because you recognise that in the clinical area, you can then take that forward to the university and make sure that it happens in the way that you think it ought to happen. (LP3)*

### ‘Emotional intelligence’

Emotional intelligence describes the capacity to use emotions to guide behaviour and thinking. None of the lecturer-practitioners who were interviewed used the term, a concept which is gaining popularity in the leadership literature (Salovey & Mayer 1997; Goleman 1996). However, for the purpose of data analysis for this study, it appears to be an appropriate term to describe their ability to understand how other people work and what motivates them in order to work collaboratively with them. This collaboration often resulted in enhanced outcomes for the lecturer-practitioners and those they worked with. Managing relationships with colleagues in practice and at the university, and with students, was a skill lecturer-practitioners deliberately used and developed in order to achieve their goals.

*I'm very, very conscious when I go into the clinical setting that I don't either tread on toes or I'm very much aware of the senior midwife on duty, say, in the delivery suite and including her in anything that I'm doing or involving her or making sure that she's aware of why I'm there and what I'm doing and what I hope to achieve. (LP6)*

*It is useful to be approachable, to never turn people down, to never get cross when they cancel your sessions or when only two people turn up [for a teaching session]. It's just being tenacious and just hanging in there the whole time. It's about making as many contacts as you can because invariably you*

*don't know everything, or sometimes anything, and if you can approach an expert and get them in, then so much the better. It's about evaluating your role and selling it appropriately and selling it in different ways to different people. It's about being Machiavellian. (LP4)*

Emotional intelligence for the lecturer-practitioners was also about recognising and monitoring their own feelings in order to deal with the disappointments and frustrations inherent in their role. Despite experiencing difficult challenges, having to negotiate other peoples' unrealistic expectations of them and having to manage uncertainty and ambiguity, the lecturer-practitioners attested to their continued motivation for their role.

## Personal support

Lecturer-practitioners reported that they received support from three sources: the university manager, their workplace manager and their peers. All participants commented on being valued and trusted by their university manager who was responsible for all the lecturer-practitioners taking part in this study. The university manager's capacity for supporting individuals within their unique practice contexts, as a result of an acute awareness of the needs of both institutions, enabled and empowered them to make a success of their role. Management support at the workplace varied, and lecturer-practitioners were not always sure that their role at the university was entirely understood or that their educational input at the workplace was valued. Accounting for their time, reportedly, was an important dimension for workplace managers whose financial contribution to the role in whole-time-equivalent terms was usually above half. However, how they spent their time required flexibility and integrity on their part, and trust on the part of management:

*You can't apportion your time into neat little boxes. You try and do it, but it doesn't work like that. The teaching doesn't work like that. Juggling timetables. It has to be very, very flexible. So you have to have a sort of people management system that is grown up and trusts you. (LP10)*

*It has to be a post of trust, because you can't tick little boxes and say where you will be every minute of the day. I think most people give far more than their pound of flesh. The workload is*



*huge, but, if you're... you know, you can get it done. You need support. And you don't need masses of form filling and things accounting for every little bit of your movement. There has to be an element of trust. (LP4)*

Lecturer-practitioners commented positively on joint job descriptions, appraisals and objective-setting which ensured that managers from both university and practice workplace were aware of their workload and responsibilities in the partner institution. This role integration between the two organisations also facilitated an overall clarity of purpose mitigating against the potential threat of role conflict and work overload.

The seniority of the post was vital as it gave post holders the authority to function in a leadership role within both organisations. In the workplace, for example, post holders were driving policy at departmental and organisational level, were responsible for identifying and responding to staff's educational needs, and were leading up practice development projects, often working alongside senior colleagues from other health professions. At the university, post holders taught on pre- and post-registration units, some lecturer-practitioners also led units, developed open and distance learning materials and contributed to curriculum development.

The two-monthly meetings for lecturer-practitioners with their manager at the university were an important source of support as it enabled a sharing of successes and difficulties and increased collective confidence in what the role was trying to achieve across different areas of practice.

*Going to the LP meetings at the university is quite useful because you get to meet all the other LPs and everybody's in the same boat. There are a lot of LPs at Bournemouth, as you know, and I think that's a really good thing. I think it's a good thing there are so many LPs at Bournemouth because everybody knows each other's job. At the end of the day we're all teaching different things, but you all have similar problems and it's useful to be able to chat about that. It's good to have a base at the university. I share the office with the others that work on the critical care courses and that's really, really useful because, of course, all our course documentation stuff is all shared and we keep all that in the office. So the university side*

*is very, very supportive and everybody works very hard. I'm not saying I work harder than anybody else at all. Everybody works very, very hard. But they're very supportive. (LP3)*

Lecturer-practitioners in this study described unique forces for the development of their role which were bound up in the context of their particular organisation and department. They were often involved in the setting up of the role, in the drawing up of the job description and in the negotiations between the managers of both organisations. Their enthusiasm and motivation saw them through the challenges and hurdles of the first year. Interestingly, the role did not merge with the individual post holder as can occur with new roles. The role itself maintained its own inherent value as clinical workplace managers filled the lecturer-practitioners posts when the initial post holder moved on. Had the role not proved valuable, managers would have been likely to shift funding to other priorities.

## The managers' perspective

From the managers' perspective, the impact of educational roles in practice was fourfold and confirms aspirations as well as anecdotal evidence. Managers reported that the roles contributed to:

- Creating and sustaining a learning environment which supports and motivates staff and students to develop professionally;
- Improving recruitment and retention in their practice area;
- Facilitating practice and service development within their practice area and throughout the organisation;
- Improving patient care.

Creating and sustaining a learning environment which supports and motivates staff and students to develop professionally

Although lecturer-practitioner contributions to pre-qualification education were acknowledged, the managers' focus was on their existing workforce rather than on students. There was agreement among all participants that education and a positive learning environment for all staff are vital for safe, evidence-based practice. The value of the lecturer-practitioner role was seen to be in connecting learning in the academic and the practice setting by 'bringing the university into the hospital' thereby tackling the issue of mediating between theoretical input at the university and practice experience; the 'theory-practice gap'.

Some managers gave accounts of clinical staff seeing the lecturer-practitioner as an 'insider', a member of their team, and were therefore less likely to feel threatened by educational or developmental activities. However, some participants commented that the prevailing culture in the clinical area needed to be favourable. In other words, the appointment of a lecturer-practitioner could not be expected to provide the solution to problems of low morale or poor practice.

The potential risk of other staff abdicating responsibility for educating others once an individual with specific educational responsibilities had been appointed was identified. There was an acknowledgement that workplace learning required an infrastructure of educational support, which the lecturer-practitioner was ideally placed to co-ordinate and lead, but not provide single-handedly. Some managers commented on the benefits of having several educational roles with specific foci, e.g. to support pre-registration students, to assist new qualifiers with the role

transition from student to registered practitioner and to provide guidance for qualified staff in maintaining their professional development. These roles could be led and supported by the lecturer-practitioner.

Improving recruitment and retention in their practice area

The majority of managers commented that investing in educational roles has contributed to improving staff recruitment. Managers commented that potential applicants with the appropriate qualifications and experience are more likely to choose to work within an environment that values and promotes education and professional and personal development of staff through offering the support of lecturer-practitioners than in those that don't. Similarly, managers indicated that retention was improved for the same reason. Although specific data supporting this view could not be produced, there was anecdotal evidence that areas which employed a lecturer-practitioner developed a reputation for valuing education and attracted job applicants more readily than before the lecturer-practitioner appointment took place.

Facilitating practice and service development within their practice area and throughout the organisation

In order to have an impact on practice and service developments, managers identified the importance of lecturer-practitioners' authority in the clinical as well as in the educational setting. Most managers saw the lecturer-practitioner role as complementary to that of the ward leader and the senior nurse of the directorate, which required sufficient seniority to influence the organisation of care and the management of the service. Some managers saw the lecturer-practitioner as part of the senior management team with strategic involvement while others viewed the role as commensurate with that of a ward leader with access to management through the senior nurse.

All participants maintained that the lecturer-practitioner's active participation in clinical service delivery in their area of expertise was crucial to the success of the role through modelling professional behaviour and therapeutic interaction with patients. Managers expected lecturer-practitioners to be highly visible in the clinical area but acknowledged that they had a crucial role to play in the delivery of educational programmes at the academic institute.

Improving patient care

Education was seen to be key to service improvements. From the managers' perspective, educational roles, in particular the role of lecturer-practitioner, affected improvements in patient care in several ways. Firstly, they positively influenced practitioners' competence and

clinical skills by providing a systematic approach to the facilitation of learning, while at the same time being able to meet individual practitioner's needs. As mentioned previously, their ability to act as role model was an important attribute in this context, too. Furthermore, lecturer-practitioners were uniquely placed to assess learning needs in response to changes in policy or care delivery, to design and deliver work-based programmes and to assess and evaluate their effectiveness. Secondly, they initiated and introduced Trust-wide changes in policy as a result of their critical evaluation of research, directly affecting patient care. They significantly contributed to the implementation of changes in practice as a result of their understanding of the educational implications for staff. Thirdly, some lecturer-practitioners provided specific services directly to patients, thus improving their care.

## Discussion

The perennial theory-practice gap in nursing was the major theme emerging from the study. The lecturer-practitioner role was often quoted as an initiative to bridge it. Indeed the 'bridging function' that participants described in their contribution to this study served to refine our understanding of the theory-practice gap to include: the connection that is created through the medium of the lecturer-practitioner role in terms of professional education and professional practice; the organisational link between the practice institution and the university; and the challenge of bringing research evidence into practice.

The notion that lecturer-practitioners bridge theory and practice was asserted by all participants in this evaluative study. However, this notion remained largely unexamined insofar as the mediating process, in other words the 'how' question, was not addressed directly. Nevertheless, inferences could be drawn through the analysis of the copious data which the 27 interviews yielded. Some of these inferences will be discussed in terms of the 'value added' by the role to the university, to the practice institution and to the profession of nursing.

### 'Value added' to the university

Investing in the role of lecturer-practitioner has brought considerable benefits to the university as students are taught in the classroom by those who are immersed in practice. As teachers, they are not only clinically credible, but also enable students to identify links between, for example, propositional knowledge in biology or psychology and its relevance to patients' experience of illness. Eraut et al. (1995) identified that explicitly mediating between those aspects of the curriculum is vital for pre-registration students' ability to transform propositional knowledge into knowledge for practice.

Figure 1: The role of the LP in pre-registration learning

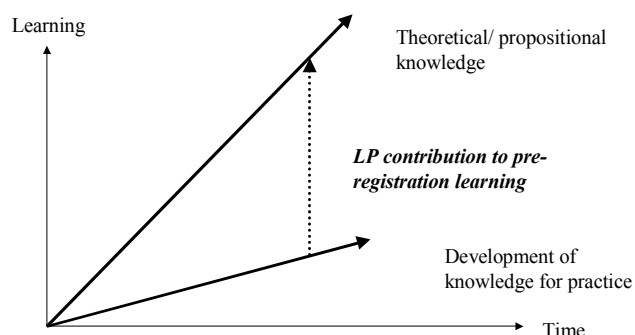


Figure 1 illustrates how this contribution to pre-registration learning may be conceptualised. The horizontal axis represents the time line, the vertical represents the pace of students' learning. The line labelled 'theoretical/propositional knowledge' indicates that the acquisition of this type of knowledge may outpace a student's ability to develop knowledge for practice. In other words, it is relatively easy to grasp propositional knowledge when it is presented in lectures, seminars, tutorials, textbooks or journal articles, as it stays constant. However, transforming that knowledge in a way that informs practice and underpins practical skills involves more than the student's cognitive skills. Therefore, knowledge for practice takes longer to develop. Here the notion of a gap arises.

This study suggests that lecturer-practitioners may expedite this process by, firstly, assisting students in making connections between theoretical knowledge and its relevance to the practice context through descriptions and discussion of relevant practice and, secondly, through encouraging them to focus on salient issues of practice when on placement. Thus, it can be argued that lecturer-practitioners 'scaffold' students' development of practice knowledge. For post-registration students this function is enhanced as lecturer-practitioners often work directly with students in the workplace, enabling them to further support students' development of practice knowledge in day-to-day situations.

'Value added' to the practice institution

From the practice institution's perspective, part of the reason for lecturer-practitioners being valued within the workplace is the undoubted contribution of the role to the government policy to

‘modernise’ the NHS workforce (DoH 2000). Education has been a cornerstone of this policy which has demanded the development of effective partnerships between the practice institution and the university. The aim of these partnerships is to improve the practice learning experience of pre-qualification health care students and to develop the workforce to support the implementation of changes in service delivery like, for example, the national service frameworks. The ultimate aim is to improve patient outcomes and the quality of patient care. The lecturer-practitioner role embodies this partnership, and this study certainly demonstrates that lecturer-practitioners have made a contribution towards that aim.

Lecturer-practitioners’ ‘bridging function’ between research evidence on one hand and practice or service provision on the other will also have made the role attractive to practice institution managers. The lecturer-practitioners who participated in this study have illuminated this function to some extent; a pre-requisite is the joint ‘owning’ of the role by both educational and practice institution through joint administration and management. Secondly, the role needs to be at sufficient seniority to invest the post holder with authority to assume a leadership position in both organisations.

At organisational level, the bridging function is diffuse and relates to policy and practice development and curriculum and curriculum content development. The skills involved on the part of the lecturer-practitioner include networking skills, knowing key individuals in both organisations and knowing who to involve in a given enterprise; and communication skills, being both a conduit and interpreter of information and relating that information to the specific context. The bridging function in terms of linking theory and practice, or research evidence with practice development, is carried out by lecturer-practitioners through direct contact with individual practitioners or students. In other words, the bridging function cannot be cascaded or distributed, but relies on the individual’s skills through direct contact in the workplace or in the classroom.



Figure 2 :The role of the LP in work based learning learning

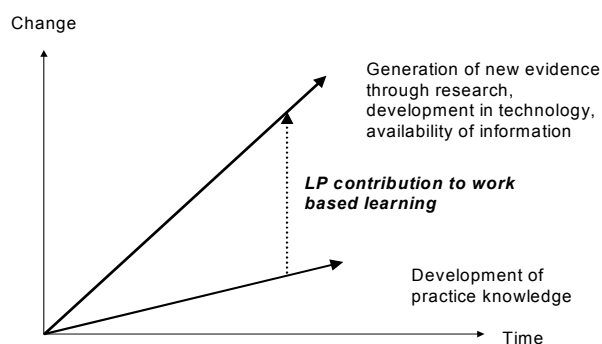


Figure 2 illustrates how the lecturer-practitioner role in work based learning may be conceptualised. The horizontal axis represents the time line, the vertical represents the pace of change.

In today's world, the generation of new information and technology will always outpace the practitioners' ability to turn it into practice knowledge and develop practice and services accordingly. Here, again, the notion of a gap arises. This study suggests that the major contributions of the lecturer-practitioner role are, firstly, towards the management and possible reduction of time lag and, secondly, lie in the development of practice through work-based education and making academic curricula progressively more responsive to practice.

This suggestion is supported by recent literature which has identified the role of the lecturer-practitioner as a possible medium through which research evidence can be 'particularised' and implemented in the workplace (Wright 2001; Thompson 2001). However, there has been a lack of evidence to evaluate its impact in terms of practice development and lasting improvements in patient care. A plausible explanation in light of the findings of this study may be that lecturer-practitioners are highly skilled in working through practitioners who then develop practice and care, rather than working as 'hero-innovators' who can be directly accredited with quality improvements. Nevertheless, managers were able to recognise how lecturer-practitioners contributed to an increase in the quality of services within their workplace. Furthermore, they sought to re-appoint to lecturer-practitioner vacancies rather than shifting funding to other areas, which indirectly attests to their worth in the practice institution.

‘Value added’ to the profession of nursing

In their journey as lecturer-practitioners, the participants in this study started out as senior clinicians. In their new role they sought to educate themselves in order to educate others. Through a process of learning and self-development against the backdrop of practice they were able to identify strongly with students and practitioners in their own environment. They were able to articulate needs regarding student-, practitioner- and practice development. The spirit in which they acted on this knowledge, through developing services and policy or in creating learning materials or units of education, was one of collegiality, so that their own learning became distributed among students and practitioners with whom they were directly involved. Learning became a mutual, two-way process. In other words, their motivation for self-development was the development of others. Thus knowledge did not accrue with lecturer-practitioners as individuals, bestowing on them special expertise and status, but was distributed among groups of practitioners and students.

In terms of evaluating the role, this way of working by lecturer-practitioners presents several challenges. If learning becomes distributed among groups and teams, how can that learning be captured and evaluated? How does the lecturer-practitioner influence group learning processes and how can this be explored? Cullen et al. (2002) comment that despite the increased recognition of the importance of team working, there is little known about learning processes in groups. However, understanding such social and collaborative learning is vital in order to develop frameworks for evaluation that are suitable and produce meaningful data to inform our understanding about how nursing knowledge is mediated at universities and in practice institutions. This form of learning challenges traditional notions of expertise, working identities and working relationships. These notions still have currency within and outside the nursing profession and may explain why learning outcomes continue to be understood solely as competencies and skills.

The traditional notions of professionalism view knowledge as a personal possession requiring mastery and control in order to create order and reduce uncertainty (Davies 1998). Individual autonomy, independence and competition are highly valued within this paradigm. An alternative concept of professionalism has been emerging, focusing on reflective practice, seeking knowledge as something that grows and develops from the fusion of expertise and experience and the formal with the intuitive (Schon 1983; Walmsley 1993). If we subscribe to this view of

professional knowledge, the emphasis on the individual professional recedes and leads to an acknowledgement that care is a team phenomenon, where drawing out and enhancing the contributions of others is valued (Davies 1998). This shift has implications for professional education which can no longer be seen simply as the production and reproduction of knowledge. Hammick (1998; 326) suggests that professional knowledge needs to be transformed into 'knowledge of collaborative practice'.

The findings of this study suggest that lecturer-practitioners are contributing to the creation of this knowledge of collaborative practice through the way they work with practitioners and students, as well as in and between two very different organisations. They have moved beyond closing the gap although they are faced with a new paradox:

In spite of reforms in health care policy which emphasise the value of teams working and learning together in practice settings, post-registration and practice based learning continue to be geared towards individuals rather than teams. Practice organisations continue to purchase education for individual practitioners largely because opportunities for team education are rare and more difficult to organise. Furthermore, in connection with work based learning, the notions of organisational culture and the motivation of the individual practitioner are frequently linked. Little reference is made to the influence of the dynamics of the small systems in which teams work, and to the process of learning.

Lecturer-practitioners are in a unique position to meet this challenge in learning and knowledge creation in nursing and health care, not just by virtue of the fact that they work at both the university and practice institution, but through the way they work and engage with practitioners and students.

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