The Shortage of Nurses and Nursing Faculty
What Critical Care Nurses Can Do

Debra Siela, DNSc, RN, CCNS, APRN,BC, CCRN, RRT
K. Renee Twibell, DNS, RN
Vicki Keller, PhD, RN

Abstract
Nurses are needed more than ever to support the healthcare needs of every American. Nurses make up the greatest single component of hospital staff. In 2004, of the almost 3 million nurses in the United States, 83% were employed in nursing, and 58% of those were employed full-time. However, a severe shortage of nurses exists nationwide, putting the safe, effective healthcare of Americans in jeopardy. The concurrent shortage of nursing faculty has significant impact on the potential for admitting and graduating sufficient numbers of nursing students to address the shortage of prepared nurses. A close examination of the demographics of the 3 million nurses provides a context for an in-depth discussion of strategies that critical care nurses can employ to help alleviate the nursing and nurse faculty shortages.

Keywords: classroom faculty, clinical faculty, clinical nurses, laboratory faculty, nursing faculty shortage, nursing shortage

Where Are Nurses Currently Employed?
Overall, 56.2% of all working registered nurses (RNs) were employed as hospital nurses in 2004, which was a decrease from 2000. The next highest employment setting for nurses was in community and public health settings, followed by nursing homes and extended care facilities. The percentage of nurses working in ambulatory care centers

Debra Siela is Assistant Professor of Nursing, Ball State University School of Nursing, 2000 University Ave, Muncie, IN 47306 (dsiela@bsu.edu). She is also the ICU CNS at Ball Memorial Hospital, Muncie, Indiana.
K. Renee Twibell is Associate Professor of Nursing, Ball State University School of Nursing. She is also the nurse researcher at Ball Memorial Hospital, Muncie, Indiana.
Vicki Keller is Assistant Professor of Nursing, Ball State University School of Nursing, Muncie, Indiana.
increased slightly from 9.5% in 2000 to 11.5% in 2004. In addition, the percentage of nurses working in various other settings increased from 4% in 2000 to more than 8% in 2004.

The American Association of Critical-Care Nurses (AACN) generates a membership demographics summary every year. The 2007 demographic summary reported that of the critical care nurse members of AACN:

- 16% work in a combined intensive care unit (ICU)-coronary care unit (CCU);
- 16% work in an ICU;
- 11% work in a some type of progressive care unit;
- 10% work in a cardiovascular-surgical ICU; and
- 7% work in a CCU.

Smaller percentages work in a medical ICU, surgical ICU, medical-surgical ICU, emergency department, pediatric ICU, recovery room, trauma unit, and neuro-ICU.

**Education, Age, and Ethnicity**

In 2004, initial educational preparation of RNs included diploma, associate, and baccalaureate programs.¹ To meet more complex demands of today's healthcare environment, a federal advisory panel has recommended that at least two thirds of the basic nurse workforce hold baccalaureate or higher degrees in nursing by 2010.¹ In 2004, 30.5% of nurses held a bachelor of science in nursing (BSN). Thirteen percent of nurses held a master's or doctorate degree as their highest degree, with less than 2% actually holding a doctorate degree.¹ The AACN critical care nurse members report the following as their highest degree:

- BSN 54% bachelor of science in nursing
- associate degree in nursing 21%
- master of science in nursing 15%
- associate degree (AD) 4% in nursing
- master of science 2% in another field
- bachelor of science 2% in another field

In 2004, the average age of RNs was 46.8 years, and 26.6% of all nurses were younger than 40.¹ In addition, only 8.1% of all nurses were younger than 30. More than one fourth of all nurses were aged 55 years or older. The 2007 AACN Member Demographic Data revealed the following age information for critical care nurses²:

- 18 to 29 years, 5%
- 30 to 39 years, 19%
- 40 to 49 years, 32%
- 50 to 59 years, 35%
- 60+ years, 9%

Regarding racial and ethnicity backgrounds, the vast majority of nurses are non-Hispanic whites followed in order by black/African American, Asian or Pacific Islander, Hispanic, American Indian/Alaska Native, and 2 or more racial backgrounds. In 2004, men accounted for 5.7% of all nurses, which increased only slightly from the 5.4% of all nurses in 2000. The 2007 AACN Member Demographic Data reported that 90% of critical care nurses are women and 10% are men.²

AACN critical care nurse members report the following ethnicity groups²:

- white, 81%
- Asian, 11%
- African American, 4%
- Hispanic, 3%
- Native American, 1%

**Advanced Practice Nurse Statistics**

Advanced practice nurses (APNs) include clinical nurse specialists (CNSs), nurse practitioners (NPs), nurse anesthetists, and nurse midwives. In 2004, there were 240,461 APNs or slightly more than 8% of the total RN workforce, an increase from about 7% in 2000. Most APNs are NPs followed in order by CNSs, nurse anesthetists, NP/CNS, and nurse midwives.¹ The 2004 National Critical Survey conducted by AACN found that 42% of 300 critical nursing units in 120 hospitals across the country had hospital-employed CNSs. Only 16% of these critical care nursing units had hospital-employed NPs.¹

**Nursing Shortage Facts**

In 2004, it was found that despite an increase of 185,000 hospital RNs since 2001, a shortage existed in most hospitals. In March 2005, a survey found that the average RN turnover rate in hospitals was 13.9%, with a vacancy rate of 16.1%. More than 1 million nurses will be needed by 2012 to care for the healthcare needs of Americans. Registered nursing is the...
Contributing Factors to the Nursing Shortage

Many reasons currently exist for a nursing shortage. Factors that contribute to the shortage include:

- Enrollment in schools of nursing is not growing fast enough to meet the projected demand for nurses over the next 10 years. In 2004, there was a 14.1% increase in enrollment in BSN programs from the previous year. However, it will need to increase to at least 40% to meet the demand.¹
- The total population of RNs is growing at the slowest rate in 20 years.
- Changing demographics among Americans signal a need for more nurses to care for the aging population.
- Job burnout and dissatisfaction are driving nurses to leave the profession.
- High nurse turnover and vacancy rates are affecting access to healthcare.

These factors indicate that we need more nurses than we can currently educate, and even after nurses enter the workplace, keeping them there is problematic. One key factor in the inability to graduate enough nurses from educational programs is the shortage of nursing school faculty. The lack of faculty restricts nursing program enrollments.⁵

Data regarding nursing school enrollment show:

- Enrollments in basic RN programs increased in 2000 to 2006 from 181,415 to 290,309.⁶
- Enrollment in master’s and doctoral programs increased from 33,044 to 36,412 during 2000–2004.⁶
- US nursing schools turned away 37,514 qualified applicants from BSN and graduate nursing programs in 2004 because of insufficient numbers of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints.⁷
- Three quarters of the nursing schools responding to the 2004 survey pointed to faculty shortages as a reason for not accepting all qualified applicants into nursing programs. With fewer new nurses entering the profession, the average age of RNs is going up.⁷

Nursing Faculty Shortage Facts

Schools of nursing have been experiencing shortages of qualified faculty for many years. In 2004, there were 48,666 nurses whose primary nursing position was that of nursing faculty.¹ Now that nursing school enrollments have increased, there is a much more profound need for nursing faculty and a very small pool of qualified nurses to fill these roles. Estimates of the total number of nurses working as nurse educators/faculty in the United States range from 41,605 to 48,666.²⁴ Although numbers and percentages of faculty increased from 2002 to 2006, there were still 869 vacancies in baccalaureate and higher degree programs and 564 vacancies in AD programs.⁶ These numbers represent a 7.9% baccalaureate and higher degree faculty vacancy rate and a 5.6% vacancy rate in AD programs. Many factors play a role in the nursing faculty shortage. One of these factors is the aging of nursing faculty. In 2004, the average age of all nursing faculty was 46.8 years. The average age of faculty with doctorates is 55.7 years.¹ In addition, only 12% of nursing faculty are younger than 34 years. Another relevant fact is that as faculty age continues to climb, there is a narrowing of the number of productive years left during which many nurse educators can teach. A wave of faculty retirements is expected across the United States over the next decade, with 2015 expected to be the year when the most retirements will occur.⁷

Factors Contributing to the Nursing Faculty Shortage

Many factors contribute to the nursing faculty shortage, one being that higher compensation in clinical and private sector settings is luring current and potential nurse educators away from teaching.⁹ Master’s and doctoral programs in nursing are not producing a large enough pool of potential nurse educators to meet the demand. Some schools of nursing are beginning to again offer nurse educator programs or courses.¹⁰ Historically, there are long lead times to become nursing faculty. Nurses usually work between completing their undergraduate degrees and entering graduate programs, then go to graduate school part-time, thus reaching their forties before they begin teaching.¹¹

Doctorate of nursing practice (DNP) programs are now being developed and implemented in many schools and colleges of nursing across the country. The American
Association of Colleges of Nursing recommends that by 2015 the DNP degree should replace the master's degree as the basic educational preparation for APNs that specifically includes the advanced practice nursing role of nurse practitioners.\textsuperscript{12} As DNP programs increase in number, more faculty members will be needed to teach in these programs, thus relatively increasing the nursing faculty shortage. Speculation per the American Association of Colleges of Nursing exists that future DNP graduates will be able to help alleviate the nursing faculty shortage by taking additional courses in education and joining nursing faculty ranks.\textsuperscript{12}

What to Do About the Nursing Faculty Shortage?

Many approaches have been suggested to address the nursing faculty shortage, including increased government funding for masters education, creative redesign of how education is delivered, and retention strategies for current faculty. One strategy for alleviating the faculty shortage is for clinical nurses to consider a dual role as faculty. Many critical care nurses seem to enjoy new challenges. Critical care nurses may want to take on a new and exciting challenge, such as a dual faculty member-clinical nurse role. How can a critical care nurse determine whether a dual role is a good decision for him or her? What can faculty do to encourage clinical nurses to consider a dual role?

Strategies for Clinical Nurses Considering a Dual Role

A clinical nurse is a nurse who is practicing in a clinical institution, such as a hospital. A faculty member is a nurse who is employed by an academic institution to teach nursing. If considering a dual role as both a clinical nurse and a faculty member, a critical care nurse will want to acquire a significant amount of information about the nature of a faculty position, the requirements and responsibilities of faculty members, and the day-to-day realities of a dual role. As clinical nurses collect information, they will be comparing their interests and abilities with the varying aspects of the faculty role, deciding whether a dual role is the right role at the right time for them (Figure 1 and Table 1).

![Figure 1](image-url)
The focus of faculty members is to facilitate the learning of students. Nursing faculty prepare licensed practical nurses (LPNs) and RNs for entry into the practice of nursing. Nursing faculty also teach in graduate programs at the master's and doctoral level, where nurses are prepared as APNs, nurse educators, nursing administrators, nurse researchers, and in other leadership roles. As a resource when collecting information on the faculty role, the clinical nurse may benefit from the National League for Nursing (NLN) Web site (www.nln.org/facultydevelopment/corecompleter.htm). The NLN is an organization that oversees all facets of nursing education in the United States. A main competency of the faculty role is described by the NLN as “creating an environment in classroom, laboratory and clinical settings that facilitates student learning and the achievement of desired cognitive, affective, and psychomotor outcomes” (emphasis added). As a resource when collecting information on the faculty role, the clinical nurse may benefit from the National League for Nursing (NLN) Web site (www.nln.org/facultydevelopment/corecompleter.htm). The NLN is an organization that oversees all facets of nursing education in the United States. A main competency of the faculty role is described by the NLN as “creating an environment in classroom, laboratory and clinical settings that facilitates student learning and the achievement of desired cognitive, affective, and psychomotor outcomes” (emphasis added).

In past decades, faculty members lectured while students passively listened. However, in the current paradigm of education, faculty do not simply teach information but rather support students’ learning. The difference between teaching and supporting learning is an important one that critical care nurses will want to explore as they consider a faculty role. For example, rather than lecture for 2 hours on hemodynamic monitoring, an astute faculty member will engage student in presenting “real-life” case scenarios along with hemodynamic monitor printouts. The faculty and students together will explore possible interpretations and propose decisions based on the data set. Alternatively, the “real-life” hemodynamic case scenarios may be available on-line for students and faculty to review and discuss asynchronously.

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Clinical expertise is a necessary, but not sufficient, criterion for teaching nursing students. Expert critical care nurses may have the clinical knowledge to try a dual role if they are willing to learn the science of teaching and learning. Just as there is evidence required for clinical nursing practice, evidence also guides the teaching practices of faculty members. For example, research suggests that nursing students learn some skills best in simulated contexts. Therefore, faculty must now plan and use computerized patient simulation scenarios and actual simulators, along with branching logic software that may accompany nursing textbooks.

Master Faculty Competencies

A clinical nurse considering a dual role will benefit from reviewing the Core Competencies of Nurse Educators. The competencies focus on supporting learning and contributing to the academic functioning of faculty. In the core faculty competencies, the clinical nurse may notice activities that sound somewhat foreign, such as formulating program outcomes, designing curricula, and understanding the social, economic, and political forces in higher education. Clinical nurses may know more about some of the underlying processes of the competencies than they first realize. For example, some competencies are based on quality improvement, evidence-based decisions, cultural sensitivity, leading change, and serving in institutional governance. All of these basic ideas are familiar to clinical nurses in a professional practice environment. Their existing skills in these areas can be transferred to the academic setting and then refined through graduate courses, serving on curriculum committees, and mentoring.
Faculty members may participate in scholarly inquiry and productivity as a way of building the science of nursing and nursing education. Scholarly productivity is required for faculty members to be eligible for tenure. Tenure is a special condition of employment that faculty members may earn through a rigorous process of demonstrating excellence in supporting students’ learning, conducting research, publishing in professional venues, and providing community service. Tenure typically enhances a faculty members’ likelihood of having ongoing employment from year to year but does not completely guarantee job security. Tenured faculty almost always have earned a doctoral degree in nursing.

Experience a Day in the Life
As a step in collecting information on the faculty portion of the dual role, the clinical nurse will want to experience what faculty members actually do in the clinical, classroom, and laboratory settings. Contact faculty members and ask about interviewing and shadowing them on a typical work day. Although few individuals enjoy every aspect of any occupation, clinical nurses would hopefully be excited about learning to do many activities in the role they accept.

Clinical Faculty
Clinical faculty are faculty members who supervise students in clinical settings, such as hospitals, clinics, homes, and long-term care facilities (Table 2). Clinical faculty are responsible for assigning students to experiences where they can achieve the learning objectives of the course in which they are enrolled. Faculty may directly make assignments, oversee self-assignment by students, or delegate assignment making to staff at the site. Clinical faculty then provide direct supervision of students as they perform nursing activities. The faculty members ensure that students deliver safe, appropriate care, as do the nursing staff who are assigned to the patient and who work collaboratively with the students and faculty. Clinical faculty evaluate students’ knowledge and actions through direct observation, individual and group conferences, written work, and commentary from the staff. Clinical faculty provide feedback to students about their progress and areas in which they need improvement. Clinical faculty may assign grades to students in some academic settings.

Clinical faculty greatly benefit from current expertise in the area in which they are supervising students. Critical care nurses who know the critical care practice setting can guide students in successful, safe decision making. When supervised by faculty who are clinical experts, students are more at ease, confident, and able to learn.14

Laboratory Faculty
Faculty who supervise in skills laboratories focus on psychomotor functioning and critical thinking of students (Table 2). Laboratory faculty provide instruction and demonstration of skills, such as starting intravenous access devices, positioning patients, and administering medications. In some academic settings, laboratory faculty also evaluate students’ performance of skills. The laboratory faculty usually oversee stocking the laboratory with supplies and scheduling of the laboratory space and equipment. A new facet of skills laboratories is the use of simulators to shape students’ thinking. Simulators are highly technological, expensive “dummies” that can be programmed to present certain symptoms to which students respond. Laboratory faculty must understand how to program the simulators and supervise their use. Simulators assist in developing higher-level cognitive skills in a safe environment where real patients are not affected by student decision making.13

Clinical faculty are often well prepared to become laboratory faculty because they know the basic psychomotor skills required for safe patient care. New laboratory faculty may need to learn some new skills. More importantly, new faculty will need to learn how to evaluate student performance and give feedback. Schools vary in how students are evaluated and how feedback is given. Until the new faculty member learns the “norms” of the faculty regarding the skills laboratories, some anxiety may be expected.

Classroom Faculty
Faculty who provide classroom teaching, also called “didactic teaching,” choose and design strategies that support student learning of nursing knowledge (Table 2). Strategies may include case studies, small or large group discussion, online modules, writing papers, individual or group presentations, participating in games and dramatic re-enactments, and study group
sessions. Classroom faculty assess learning styles of students and choose activities on the basis of how students optimally learn specific content. Classroom faculty need astute communication skills to clearly relay course information and learning expectations. Classroom faculty also benefit from an ability to ask interesting questions that probe student understanding and stretch student learning. Successful classroom faculty have strong relationship-building skills to develop effective student-teacher partnerships. Access to classroom faculty is important to students, because faculty are expected to answer questions, remediate, respond promptly to e-mail, refer to academic resources, and counsel students as needed.

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<th>Table 2: Dual Roles, Requirements, and Responsibilities</th>
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<sup>a</sup>In some states, nurses with a BSN degree working on a master’s degree in nursing may teach.
Classroom faculty are responsible for composing reliable and valid measurements of student learning, including examinations and quizzes. Classroom faculty assign course grades to students. Classroom faculty may be viewed as course leaders who communicate information to students, other faculty, and administrators. In some institutions, classroom faculty may be required to have doctoral degrees.

Self-Assessment
As a clinical nurse gathers information about a possible dual role, the nurse can benefit from a self-assessment. Self-assessments help identify areas of professional strengths, weaknesses, and possible career paths. A simple decision-tree may help guide a clinical nurse who is considering a dual role as faculty member (Figure 1). Another resource for self-assessment to include when considering a change within your nursing career is available at www.nurseweek.com/career/assess/mainFrame_assess.html.

Begin a Graduate Degree Program in Nursing
After collecting information on the faculty portion of the dual role and conducting a self-assessment, a clinical nurse may recognize the need for more education. If the nurse does not yet have a master's degree in nursing, it may be time to begin a program. Obtaining a master's degree in nursing is a necessary step in preparing for a role in academia. A minimum of a master's degree is required in most states to teach AD or baccalaureate degree nursing students and is recommended to teach LPN students. In some states, a new faculty member can be hired while pursuing the master's degree, with the stipulation that the degree be completed in a given length of time, often 5 years. A doctoral degree is recommended for faculty who teach master's students and is required to teach in doctoral programs. The master's degree usually needs to be in the field of nursing, rather than a related field. Consensus is building across the profession that only nurses prepared at the master's level in the discipline can adequately teach undergraduate nurses. Some schools hire nurses with master's degrees in other fields and pair them in teaching assignments with nurses who have master's degree in nursing.

The cost of obtaining a masters degree ranges from slightly more than $4000 in public institutions to more than $11 000 in private institutions. Tuition reimbursement by clinical institutions eases the financial burden of obtaining a master's degree. Online programs, which are proliferating, reduce the burden of traveling to class and provide flexibility for nurses with time constraints.

If a clinical nurse eventually wants to be tenured as a faculty member, a doctoral degree is usually required. Tenure provides more income and job security. Doctoral programs take 3 to 5 years to complete and can be taken online or on-site. Doctoral programs in nursing that result in a PhD, DNSc, DNS, or DSN degree may or may not include education courses, although many of these doctorally prepared nurses become nurse faculty. Doctoral programs that prepare a nurse to be in the role of a nurse educator or nurse faculty are either PhD or EdD programs.

Most of the new DNP programs do not include preparation as an educator because the focus of a DNP program is to prepare APNs to function in an advanced practice role that includes leadership and health policy skills. However, the DNP-prepared nurse may still be hired in an academic role, pending completion of education courses. DNP graduates will likely seek leadership roles in a variety of practice settings, including managers of quality initiatives, executives in healthcare organizations, directors of clinical programs, and faculty positions responsible for clinical program delivery and clinical teaching. New BSN-to-PhD programs are also an option.

Choose a Faculty Mentor
Critical care nurses who are intrigued with a possible dual role as a faculty member could benefit from a faculty mentor. A faculty mentor can provide encouragement as clinical nurses weigh the advantages and disadvantages of a dual role. The mentor can reassure critical care nurses that they can be successful and can help them transfer existing skills to an academic teaching environment. The mentor might offer to write a letter of recommendation to submit with an academic employment application, in which the clinical nurses can see their articulated strengths and competencies. The mentor can further serve as a resource in preparing for the interview and during the academic orientation process. The mentor might let the clinical nurse job shadow and review samples of anonymous students' work to illustrate the
faculty role. Simply sending the message, “You can do this and you will have resources to meet this new challenge” can be effective.

Clinical nurses will want to select a mentor who has the abilities and characteristics they wish to attain. Personalities and working styles of mentors and mentees will ideally match or be compatible. Mentors may be found among faculty in a master’s program or from faculty at the school where the critical care nurse would like to be employed. Other potential mentors may be found by attending conferences and joining work groups, such as research teams and quality improvement initiatives. The clinical nurse can extend an invitation to a faculty person to meet and discuss a dual role. If the potential seems to exist for a professional relationship, the staff nurse can invite the faculty member to become a mentor. A mentored partnership requires regular contact and communication, which the clinical nurse will assume responsibility to initiate. If a mentorship does not seem possible, nurses in dual roles might consider comentoring each other as peers. They can find a colleague who also wants to experiment with a dual role and explore the options together, sharing information and impressions as the process occurs. Comentoring with peers often includes reflective dialogue and hastens the adjustment of new faculty to the educational role.18

**Trial Run**

Clinical nurses who are uncertain about how a dual role would work for them could maintain their clinical position and try teaching for a semester or year. For example, an ICU staff nurse might offer to teach a clinical group in the ICU for a short summer session.

**Salary**

As clinical nurses consider a dual role, they will want to evaluate the economic benefits. Full-time clinical faculty with a master’s degree may have a median starting salary of $55,000 with full benefits.7 Novice nurses with a baccalaureate degree can earn that amount in clinical settings with shift differential.11 To make significantly more money than what is earned in the clinical setting, a faculty member would need to complete a doctoral degree and a tenure process, which might yield a median salary of $65,000 to $78,000.7 Clinical nurses who teach part-time in a dual role may be paid by the course, which can range from $2000 to $5000, depending on the number of credit hours. Part-time dual-role faculty positions rarely include benefits. If benefits are important, the dual-role nurse will want to consider keeping benefits from the clinical institution, where full-time work is not always required for benefits.

Because earning more income is not a clear incentive to becoming a master’s prepared dual-role nurse, other benefits from the dual role must be valued. Indirect benefits include professional recognition, new learning opportunities, novelty in work, the social status associated with being an academic faculty member, and research experience. In addition, dual-role nurses may have the benefit of some on-campus resources, including access to computer laboratories, library resources, sporting events, and loan programs for computers. Full-time faculty may also receive tuition reimbursement for themselves and family members to pursue additional degrees or take courses for enhancement at the university. Work scheduled on the academic calendar is also a benefit in that holiday, weekends, and seasonal breaks are usually free of teaching responsibilities for dual-role nurses.

**Strategies for Recruiting Clinical Nurses for a Faculty Role**

Nurse leaders, especially faculty members, are primary recruiters of clinical nurses into dual roles. Although not evidence based, several guidelines are supported by expert opinion as effective in helping clinical nurses embrace a faculty role (Table 3). Faculty members can form warm, interpersonal relationships with clinical nurses. Clinical nurses often ask faculty members about career options. A faculty member can introduce the possibility of adding a faculty position as a dual role. Staff nurses may lack confidence that they could be a faculty member. Faculty members can offer words of encouragement and note any special gifts or abilities that the staff nurse has that would match the faculty role.

Positive communication is a key to stimulating interest among clinical nurses to consider a dual role. Nursing faculty in some locales have a reputation of complaining about their jobs and graduate study, being overworked, and being underpaid. Faculty can lend positive language to the marketing of the faculty role and talk about the benefits of a faculty position. While acknowledging the demands of a faculty position, the resources available for support can be emphasized as well.7
To interest clinical nurses in a faculty position, schools of nursing can offer on-site graduate education materials and job interview options. Critical care nurses are busy people. Early steps in investigating a faculty position can be facilitated by removing the barriers of traveling to an unknown site to apply and negotiating parking garages and look-alike corridors. Schools of nursing can offer booths at clinical events and conferences to promote faculty openings and dual roles. To further attract clinical nurses to try a dual role, academic leaders can design teaching options for dual-role nurses that include team teaching with an experienced faculty member, creating new job titles for dual-role nurses, scheduling classes at varying hours, and ensuring paid time to learn educational theory. Tuition reductions may be offered in exchange for clinical teaching.

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Targeting Special Groups
Several groups of clinical nurses may hold high potential for a successful dual-role experience. Nurses who are aging and no longer feel drawn to bedside nursing may be a pool of possible dual-role faculty members. Nurses nearing retirement have fewer options away from the bedside, because many acute care facilities are putting money into the frontline clinical positions. Not many positions are currently available that do not require a great deal of lifting and physical strain. Nurses often do not want to quit nursing all together at a certain age; they seem to draw meaning and connection from their work. Aging nurses in a dual role could teach online courses or become laboratory faculty part-time, thus conserving energy for the days they still work as clinical nurses.

Attracting younger nurses to a dual role is necessary to offset the increasing number of nursing faculty who are preparing to retire and decrease the average age of current nursing faculty. Faculty who are working in clinical settings with their students may identify early-career critical care nurses with the motivation and potential to teach students. Faculty may wish to suggest that they take a graduate education course in a nursing master’s program to evaluate their interest in teaching. Pursuing a graduate degree earlier in their careers will facilitate having career options later. Clinical nurses who have had teaching experiences in the clinical institution often transition smoothly into dual roles. Precepting, mentoring, teaching inservices, instructing patient groups, and planning educational offerings can give clinical nurses early educational skills and boost their confidence for a dual role. These activities also present clinical nurses with opportunities to develop valid and reliable pretest and posttest questions and interact with students.

NPs and CNSs may have an interest in a dual role as faculty. They may obtain a post-master’s certificate in education to gain knowledge and expertise in educational theory. Post-master’s certification may require courses in curricular design, program evaluation, course management, accreditation processes, and teaching strategies. CNSs may not have education courses in their master’s program, but they often have experience in education, because education is one of the main facets of the CNS role. Experience in the education of patients, families, and staff will position most CNSs well for a dual role, although they may need some post-master’s program nursing education courses.

Maintaining Collegial Relationships
Although faculty members may be zealous in pursuing clinical nurses to experiment with a dual role, sensitivity to the position of the clinical agency is important. The impression of “stealing the good nurses away” must be avoided. Clinical agencies must feel that they benefit—not lose—from having academic faculty in their institution. One way to provide balance is for faculty to work at the bedside or

Table 3: Strategies for Introducing Dual Roles to Clinical Nurses

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<td>Take a genuine interest in the professional development of a clinical nurse</td>
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<td>Speak positively about the faculty role and dual-role options</td>
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<td>Find out how the clinical nurses’ abilities fit the required competencies of the faculty role</td>
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<tr>
<td>Have information on graduate education readily available</td>
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<td>Speak to the costs and benefits of earning a graduate degree in nursing</td>
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<tr>
<td>Offer to guide clinical nurse through the decision making about a dual role</td>
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in other professional roles within the clinical institution. Faculty can benefit from the opportunity to keep current with clinical issues and can provide expertise in direct patient care, teaching inservices, guiding research studies, collecting audit data, and helping with performance improvement teams. An abundance of opportunities exists for faculty to contribute to the mission of the clinical institution for pay or as an act of service. Academic units can make clinical practice a priority so that faculty remain functional and useful to the clinical agency. A true partnership can be formed between the academic and clinical institutions so that both benefit from the work hours and efforts of clinical nurses and faculty.20

**Negotiating the Dual Role**

Once a clinical nurse decides to transition into a dual role, careful communication is necessary so that all parties know what to expect. Most employers require employees to sign conflict of interest/commitment contracts to clarify how resources and time can be used. Dual roles may take a variety of forms, including joint appointments, adjunct faculty, and independent employment. Special negotiations may be necessary for joint appointments and adjunct faculty roles.

**Joint Appointments**

Clinical nurses may negotiate a joint appointment for a dual role. In joint appointment contracts, one partner, either the clinical employer or the academic employer, is designated as the primary employer. The primary employer pays the nurses’ salary and benefits and holds greater power in the employment arrangement. That is, the primary employer usually gets first choice about what activities the nurse provides for them. The secondary partner “buys” the nurses’ time for a certain number of hours per week to perform specified activities. The secondary partner pays the primary partner a set amount for those hours.

An advantage of a joint appointment to the academic institution is hiring new faculty who have current clinical skills. An advantage of a joint appointment to the clinical institution is retaining clinical nurses who are expanding their nursing knowledge and teaching skills. Advantages of a joint appointment for the clinical nurse are the freedom to explore a new role in professional development without working more total hours. A disadvantage of a joint appointment can be that both primary and secondary employers demand more work of the dual-role nurse than the nurse expected. Setting boundaries and insisting on clear communication and a written contract can alleviate stress in a joint appointment.

**Adjunct Faculty**

Adjunct faculty roles are similar to joint appointments, except that the dual-role nurse is usually employed primarily by the clinical institution. The academic institution, as the secondary partner, may need the services of the adjunct faculty on a limited basis only. For example, the clinical nurse may be “loaned” to the academic institution to teach a specific course for a limited period only, say 1 semester. Adjunct faculty may be given time away from the clinical institution to teach on the short-term assignment, or the adjunct faculty may be paid directly by the teaching institution on a per course or per diem basis. Advantages for the dual-role nurse are the short-term experiences gained in the academic setting without a permanent commitment. The dual-role nurse usually has much control over the academic activities in which he or she participates.

**Independent Employment**

Some nurses prefer dual roles in which they independently contract with employers to teach or provide clinical services. As long as there are no contractual conflicts of interest, this arrangement gives dual-role nurses control over the hours and activities in which they engage in both the academic and clinical settings. Nurses holding dual roles that are independently arranged will want to consider benefit packages. Some dual-role nurses work 2 part-time jobs without benefits at either job or work one job with benefits and then work additional hours at a secondary job.

**Summary**

A nationwide nursing faculty shortage exists. This faculty shortage must be resolved in order to admit and graduate the number of nursing students needed to address the nursing shortage. A dual role as a faculty member and a clinical nurse is one strategy for reducing the faculty shortage and encouraging professional growth among clinical nurses. Strategies to introduce the dual role to clinical nurses include developing professional relationships with clinical nurses, portraying the faculty role positively,
offering to mentor clinical nurses, marketing dual roles in places accessible to clinical nurses, and creating new ways of delivering education that are amenable to the dual role.

Strategies for clinical nurses who might want to pursue a dual role include investigating the nature of the faculty role, choosing a mentor, obtaining a graduate degree in nursing, and enhancing one’s own enjoyment of teaching. Clinical nurses will weigh carefully the advantages and disadvantages of a dual role.

Dual roles may be joint appointments, adjunct faculty roles, or independent contracts. Special groups of nurses who might transition well to dual roles include relatively older nurses who want to step away from full-time clinical work, relatively younger nurses who want to sample the educator role early in their careers, and nurses who have teaching experience in the clinical setting. The careful structuring of dual roles may benefit all stakeholders—faculty, students, clinical nurses, patients, healthcare systems, and academic institutions.

References
16. Leuner J. The BSN to PhD program: a new solution to the nursing faculty shortage at the Medical College of South Carolina. SC Nurse. 2006;10:19.