

DISCUSSION PAPER

Joint or clinical chairs in nursing: from cup of plenty to poisoned chalice?

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Abstract

Aim. This paper presents a discussion of the current state of joint chair or clinical chair positions in nursing.

Background. Joint chair positions in nursing or midwifery have been popular approaches to developing clinical research and to bridging the ‘theory-practice gap’. Recent personal observations and commentaries in the literature suggest that the service-academy consensus that underpinned such positions may be crumbling.

Data sources. This paper is based on 13 years’ experience of holding a joint chair position, an extensive review of the professional literature (up to and including 2009 sources), and conversations and discussions with many professorial and joint chair colleagues.

Discussion. Despite its demonstrated success, the joint chair position may be under threat from competing and unrealistic demands from partner organizations and from changing understandings of the essential role and nature of a professor. The situation may be exacerbated by appointing inexperienced or unsuitable applicants to such key posts.

Implications for nursing. The joint chair position was a powerful initiative in nursing and midwifery with real potential. In the current climate, this potential is unlikely to be realized and nursing will be the poorer.

Conclusion. If joint chair positions are still valued and seen as key roles in developing clinical research and university-service partnerships, then serious consideration needs to be given to the current state of position. I argue for a return to trust and what Onora O’Neill calls ‘intelligent accountability’ rather than the micro-management that is so prevalent in both the health and academic industries.

Keywords: clinical chair, clinical research, joint appointment, joint chair, midwifery, nursing, professoriate

Introduction

A joint or clinical chair position is usually created as a collaborative arrangement between a university and a hospital

or health service. The post is usually at professorial level and the focus is primarily on cultivating research and developing clinical and professional practice. In the past, joint chairs or clinical chairs in nursing were among the most sought after of

all academic and research positions. This may, however, no longer be the case: organizations struggle to fill the available positions, and there is a shortage of suitably credible and experienced candidates. The consensus that existed between service and university partners about the importance of research and what counts as mutually beneficial research has bifurcated. In the place of mutually agreed research goals that blend benefits for both organizations, there are now multiple, additive and often competing demands on the chair holder. They must 'deliver' both national/international competitive research grants, high impact factor publications, full-fee-paying research students, timely PhD completions and an enviably high 'profile' for the university. Simultaneously for the hospital, they must drive service improvement, engineer professional culture change, transform nursing as practised into evidence-based practice and use their research expertise to address the service's research priorities, which are usually and variously audits, evaluations and practice development projects.

Background

What has gone wrong with joint or clinical chairs in nursing? These positions were to be the ideal strategic and operational posts that enabled holders to straddle the worlds of academia and clinical practice, developing research and scholarship, building research cultures in clinical and service areas and bridging the notorious theory-practice gap. I was working in a university in Scotland in 1995 when I applied for a joint chair position in Adelaide, Australia – the first joint chair in a Women's and Children's Hospital. Ten thousand miles is long way to travel for a great job, but I was sure that it would be worthwhile – and it was. In addition, the chances of the university and hospital/healthcare sectors in the UK collaborating and sharing resources to create such professorial positions in nursing in 1995 were virtually non-existent. I well remember a conversation at that time with one of the doyennes of UK nursing education, who acknowledged with some regret that the university sector at that time could never create such joint positions at professorial level as they would have no concept of a Professor of Nursing who was not also a Dean and Head of Department, let alone one whose office or department might not actually be in the university.

Such joint or clinical chairs were, however, thriving in Australia, and in 1996 I moved to join what was a growing scholarly community of some 20 nurses and midwives whose professorial positions were shared between service and university sectors and who were, in various ways, researching, publishing, developing scholarship and enabling research and practice development in their respective clinical areas (Dunn &

Yates 2000). Over the 13 years that I held my joint chair appointment, such chairs seemed to grow in popularity, not only in Australia but also in New Zealand, Canada and the UK. Every university and hospital or health service, it seemed, wanted to have one. Latterly, however, I believe that something has changed. This is a personal commentary, grounded in my experience of holding and developing a joint chair, informed by current professional literature and supported by numerous conversations with many current and former professorial and joint chair colleagues worldwide. I suggest that all is not well with these positions, which should, in theory at least, offer a win-win scenario for the post holder, university and hospital/service agency. It seems that these positions are becoming increasingly difficult to fill, or at least to fill with suitably qualified and experienced candidates. Over the last 4 or 5 years I received more than the usual number of contacts and calls, with which other joint chairs may be familiar, from recruiting firms and headhunting agencies seeking advice about suitable applicants for a new or vacated joint chair position. The two questions were always the same: 'Do you know of anyone who may be suitable for this new post', followed by 'Or would you be interested'? After replying negatively to the latter, I would almost always struggle to suggest any suitable possibilities for the former. Invariably more than occasionally, the recruiter would explain that they had been experiencing great difficulty in attracting suitable applicants or that they were re-advertising following initial failure to appoint. The problem is not limited to Australasia. I recently served as the international advisor/assessor to a major university and hospital in Europe advertising a joint nursing chair position. I stress here that this was a top-notch university and major teaching hospital, the kinds of place where you would expect to attract a long line of high quality candidates for such a desirable position. There were only two applicants and one of these was wholly inappropriate. Thus, for a prestigious joint chair position advertised widely across Europe and possibly internationally, there was ONE serious applicant, who ultimately was not appointed. What has happened?

Data sources

This paper is based on the personal and professional experience of holding a joint chair position for 13 years. In addition, the salient research and professional literature in English related to joint chair positions published between 1995 and 2009 was consulted via a comprehensive electronic search using MEDLINE, CINAHL, EMBASE, Science Direct, ERIC and Google Scholar and the terms 'joint chair', 'clinical chair', 'professoriate' and 'joint appointment'. Personal conversations and discussions about the current state of joint

chair positions were also held with several joint chair colleagues in different countries.

Discussion

The service-academy disjunction renewed

A joint chair should be almost the perfect professorial position. There should be opportunities for challenge, autonomy, creativity, networking, research capacity-building, developing research experience, promoting culture change, track record enhancement, publishing, cross-disciplinary and institutional collaboration, and real personal and professional growth. So why are applicants not queuing around the block for such a position? The 'downside' of the joint chair position has been alluded to in the literature, and the danger of the post-holder being expected to be all things to all people and to function essentially as if they held two or more full-time positions is no secret. Lumby warned of this over a decade ago:

Perhaps the overwhelming concern among my colleagues in clinical chairs is finding a balance between various roles of research, teaching, administration, committee work, within the university and the health care facility, student supervision, external examining of thesis, external reviewing of grant applications, networking with colleagues nationally and internationally, public speaking, writing, work-shopping, research seminars, consultancies, providing advice and support to staff in both health and education, organizing resources and undertaking clinical work, to name a few. (Lumby 1996, p. 3)

However, workload may not be the sole or even primary reason for a decline in the popularity of joint chairs. After all, the people who tend to apply for these posts are usually driven and passionate type A personalities who are not averse to hard work. Everyone is 'busy'. Indeed 'busyness' is the emblem of our times. Despite all the well-meaning noises about 'work-life balance', there is little kudos to be had in the semi-toxic health or university sectors by letting it be known that you *do not* intend to work every hour of every day. The display of such a 'weakness' or less than total commitment to your job may stand you in less than good stead at the next promotion round. A stronger likelihood is that something has changed in the nature of the positions themselves and how they are perceived in both the healthcare and university sectors. Perhaps the goalposts have changed and not for the better. This may well be indicative of a wider malaise, a more systemic disjunction between the worlds of healthcare provision and the university. As Cash (2009, pp. 106–107) observes:

The current growth of managerialism and technocratic nursing means that an alternative set of values is being offered and these are not the explicit values of the academy.

The vulnerability of the joint chair position

Joint chairs and their incumbents have always been in something of a vulnerable position. Most are fixed-term, possibly renewable, contracts of 3–5 years and subject to the vagaries of university, health or research funding budgets and personnel changes. This is not an unusual position in today's world, but is hardly an incentive if a tenured chair in the university alone is an alternative. Given the necessary time-scale involved in developing grantsmanship, winning funding, attracting and supervising students to completion of their degrees, developing research programmes and establishing collegial collaboration networks, a 3- or 5-year contract should be the absolute minimum required merely to begin to establish the position. In a landmark Canadian case study, Ogilvie *et al.* (2004, p. 115) described the 'abrupt and painful' termination of joint appointments, despite evidence of the success of the initiative. The reasons given by the university concerned were 'inadequate funding and curriculum change' (p. 115). Little wonder that the authors were sceptical about such a response, given that there can scarcely be a university anywhere *not* experiencing these phenomena. The authors' alternative suggestion has more of the ring of truth – that the faculty champion of the initiative had retired and that other influential staff had simply 'moved on to other activities'. One possibility is that the novelty of the initiative had simply worn off and people's attention was now focused on the newest 'new idea'. Equally concerning would be the possibility that this breakdown illustrates a deeper malaise at the heart of what should ostensibly be a mutually beneficial collaboration with jointly valued outcomes. I remember being similarly puzzled several years ago when three joint chair colleagues suddenly learned that their contracts would not be renewed. These were eminent researchers and scholars with sound track records and strong professional profiles. Clearly, however, not sound or strong enough for someone, or again perhaps the consensus and sense of shared purpose and mutually desired goals between hospital and university sectors is crumbling as each player seeks an ever greater slice of the 'professorial pie' and more and more 'bang for their bucks' at the expense of the greater whole.

Agreed KPIs or bigger slices of the pie?

For the university sector, the research quality assessment game will continue to play out in some guise and, given the

funding implications, they have little option but to pledge their 'full commitment' to it. Thus, for the university the key performance indicators (KPIs) mean that the holder of a joint chair must help maximize their possible research rating or risk being seen as a luxury or even an irrelevance. Whether such KPIs will align with the demands faced by the hospital or health service partner is more contentious. If the service agenda is being driven by throughput, efficiency, safety and quality, recruitment and retention and similar issues, the danger is that service managers, who may have scant understanding of the academic world, will prefer KPIs that address what they see as their more 'immediate' issues and the need for consequent service improvement – now. Research, publications, grants, PhD completions and the other key KPIs for universities, even when clearly related to service and clinical concerns, may not seem 'relevant' enough as deliverable outcomes.

Wallis (2007, p. 4) has noted the importance of consensus between the parties if the joint chair holder is not to be pulled in impossible directions:

To make sure that a Clinical Chair in nursing is not a Mission Impossible it is necessary to have key performance indicators agreed to by all three parties.

This may be easier said than done, however, and much more than just 'agreement' is necessary. In a health and education climate where continually doing more and more with less and less is an expected cultural norm, and where the subsequent re-branding of this as 'increased efficiency' does not even elicit a blush, there seems to be a growing tendency, not to synthesize mutually valuable KPIs, but instead to simply double up on the KPIs to keep both university and service sectors happy with their own 'list'. Not only will the professor be expected to be a top researcher, winning grants, establishing research programmes, publishing, supervising, teaching, leading, consulting, examining, networking, presenting and more, but in the service sector they will also be expected to be a kind of super staff development guru and contract researcher whose role is no less than to change the nursing culture of the organization, improve care and service provision quality and give the 'research answers' that will extinguish the most troublesome clinical, professional or organizational fires of the day. 'After all', you can hear the hospital executive thinking, 'we pay half of their salary, so we may as well use them'.

Chair inflation: the ten-a-penny professoriate?

This points to another tension in the joint chair role that is inextricably linked to what it means – or should mean – to be

a university professor. I am old enough to remember when the title of 'Professor' signified something quite special, but I suspect that some of that aura has dimmed through overuse, especially in the joint chair arena. WS Gilbert in 'The Gondoliers' hit this particular nail squarely on the head, noting that 'when everyone is somebody, then no-one's anybody'. I know from my assessor work and from conversations with colleagues that I am not alone in my perception that, perhaps to court 'industry partners' or to appear 'non-elitist', there has been a tendency to appoint to joint chair positions candidates whose track records and experience would be unlikely to secure them even a Senior Lecturer position interview in any discipline other than nursing. Wittingly or unwittingly, we may have created a perverse professorial version of the grade inflation phenomenon or the 'wider access' gospel. Gaining your PhD in the previous year or two does not really constitute the experience necessary to take on a joint chair post. To be a professor was once to be a scholar, teacher, writer, researcher and thinker (Furedi 2004, Gaita 2005) and to be part of a tradition far greater than yourself, your organization or the transient priorities propounded by the government or executive group of the day. A professor worthy of the title would not be simply another employee or hired gun researcher doing no more than the bidding of the school or hospital/service managers. If a full professor does not, or cannot, have a clear vision for a research and scholarship agenda that may not be a clone of the various executive agendas, it is hard to see who can. If all that is wanted by the service partner is someone who can undertake hospital-based audits and evaluations, teach staff how to do or use research and is in-service education and professional development on a regular basis, then a joint chair appointment seems a strange sledgehammer to use for that particular nut.

Implications for nursing

Ogilvie *et al.* (2004, p. 115) diplomatically posed another potential threat to the success of a joint chair position:

Joint appointment positions are particularly vulnerable as agency requirements change, roles evolve, and administrators come and go.

In the current climate of what I have described elsewhere as 'constant, capricious change' (Darbyshire 2008, p. 39), a joint chair holder has no special immunity from these factors and, some may argue, nor should they. It is more probable than possible that, during the chair's tenure, either partner organization will change its executive leaders, focus and priorities. More worrying perhaps is that it will also change its essential understanding of the role of the joint chair, the post-holder's

What is already known about this topic

- For many years, joint or clinical chairs in nursing and midwifery have been a popular approach to developing research and bridging the theory-practice gap.
- The evaluation literature shows that joint chairs are generally valued by partner organizations and that they deliver valued outcomes.
- There are indications and disquiet that the shared understandings and consensus between academic and service partners may be fragmenting.

What this paper adds

- A consideration and challenge based on personal experience of holding a joint chair position, discussion with many professorial colleagues and international appreciation of the joint chair situation.
- There is a growing danger that joint chair positions are being subject to changing and unrealistic performance expectations on the part of both service and university partners.
- Key performance indicators for joint positions need to be shared and mutually valuable to both university and service partners, rather than being unique and cumulative.

Implications for practice and/or policy

- Joint or clinical chair holders will continue to struggle in the current competitive healthcare climate unless mutual expectations are clarified and revised.
- It is a disservice to both nursing as a whole and to the new appointee to offer joint chair positions to inexperienced applicants.
- If joint chairs are to thrive, there needs to be a return to trust in place of over-reliance on audit and micromanagement.

responsibilities and what they believe the professor should be doing. The dangers here are obvious to those with any understanding of the research world. A good joint chair-holder who is fulfilling fairly universally agreed professorial KPIs will have developed a particular research programme, and will be researching, teaching, writing and hopefully winning grants, publishing, speaking, collaborating, networking, supervising, administering, serving the profession, building research and inquiry capacity and culture among clinicians and doing all of the other hidden work of a professor. Developing all of these

activities successfully takes focus, drive and *time*. Expecting a joint chair-holder to change the focus, philosophical approach, emphasis or content of their strategy and activities to fit with a new 'agency requirement' or new university/service administrator's preferred or personal agenda is as potentially destructive as it is pointless.

'Flexibility' or 'change' may not be the motherhood and apple pie 'good thing' that some imagine them to be if the underlying assumption is that a joint chair is simply another one of the Plasticine® people of health care, there to be shaped and moulded to serve the agendas of (possibly transient) others. I say transient here as 'executive churn' is a serious concern in many healthcare and university systems. In England, for example, the average 'shelf-life' of a hospital CEO is approximately 700 days (see http://www.hoggett-bowers.com/_images/_adverts/Final_NHS_Report-June_09.pdf). Similar data for Directors of Nursing or Midwifery would be interesting. In an excellent review and study of clinical chairs, Duke *et al.* (2009) acknowledge this issue and rightly propose that the joint chair and their unit be part of the service organization but simultaneously beyond the control of the organization's line management and thus protected against the vicissitudes of ever-shifting executive structures, personnel and agendas:

Based on this evaluation it is best if the positions, and associated research units, operate from within the organization but independently from the organizational structure. (p. 137)

These authors further propose that:

Minimizing operational involvement assists to enhance a Clinical Chair's ability to engage in critical reflection and challenge traditional approaches to addressing clinical issues (p. 137–138)

This is an extremely valuable point, but one that needs to be extended. I would add here that the joint chair's independence and autonomy should also enable them to engage in similar critical reflection and debate around not only 'traditional approaches' to research and clinical issues. They also need to be able to challenge and question some of the more recently espoused and fashionable approaches (see for example, Darbyshire 2008, Walker 2009a, 2009b). This situation can be fraught with difficulty if the chair holder's views do not support, or are perhaps even critical of, those held by the Dean, Director of Nursing or Midwifery or any other executive member who has line management or professional authority over them. Surely, however, such disagreements or differing perspectives should easily be resolvable by collegial discussion between the professor and executive colleagues. Perhaps, but that assumes a mutuality of purpose and shared understanding of the nature of scholarship, critique and

autonomy, especially as these should relate to a professor's work. Hospital and service executive teams value consensus. It is an accepted corporate value that their senior members are seen to be 'on message', 'singing from the same hymn sheet', 'working towards shared goals', 'exhibiting shared values' and all of the other metaphors of unity. To challenge or disagree with an executive or line manager's preferred approaches and strategies, or to decide to work from within a different paradigm or to different priorities, *regardless of the positive outcomes that these may still produce*, is to run the risk of being cast as 'not a team player' or, worse, of being somehow unsupportive towards the organization. This homogenization of thought is antithetical to the very idea of a professorship [although many critics such as Frank Furedi would argue that we have already slid too far down this particular slope of demanding that our professors and thinkers 'fall in line with current policies' (Furedi 2004, pp. 147–148)]. The finest universities used to (and I do hope that they still do) revel in the diversity of their professoriate and the views and positions that they hold. This was the fuel that fired scholarly debate and discussion. Difference of opinion was not something to be line-managed out of the discourse or performance-managed out of the organization, but something to be treasured, nurtured and modelled for the benefit of students, staff and a greater good called 'ideas', 'thinking' and 'knowledge'. Imagine a University of California Berkeley Philosophy Department insisting that John Searle and Bert Dreyfus put aside their philosophical differences and agree with each other in order to demonstrate unity. Or even worse, imagine them being told that the philosophical stance of the Department would be determined by the personal preference of the newly appointed Dean. Absurd as this seems, it mirrors the structural situation in which joint chair-holders may find themselves.

Conclusion

I present here more of a modest proposal and tentative suggestions than an ossified conclusion. Let us first consider whether joint chair positions are actually needed any longer. My concern over the current state of these positions may be entirely nostalgic or misplaced. Perhaps in hospitals and healthcare settings the world over joint chairs are thriving and successful or, in the absence of such joint chair positions, that the theory-practice gap has been overcome, academic and clinical colleagues have bonded, practice-focused research is flourishing, interdisciplinary and intersectoral co-operation is mushrooming, and staff are thinking, questioning and challenging themselves, their practices and their organization. Perhaps if, however, the joint chair role

does have a place and a future, I want to suggest some approaches to maximizing the chances of its success. Fundamental to these suggestions is the premise of personal and professional trust – a quaint, if not positively arcane notion in today's audit-obsessed world. We have created a system of 'audit', 'accountability', 'KPIs', 'measurable outcomes' and the rest of the shibboleth of security that supposedly underpins, but more probably overlays and suffocates our human services. This mythology has been comprehensively dismantled (see for example, Power 1996, 1997, Charlton 2002, Loughlin 2002, Furedi 2004, Apple 2005, Gaita 2005, Sparkes 2007), yet its influence pervades our services; this represents an 'accountability culture', as philosopher Onora O'Neill noted in her Reith Lectures (O'Neill 2002), that 'aims at ever more perfect administrative control of institutional and professional life' <http://www.bbc.co.uk/radio4/reith2002/lecture3.shtml>. Such an audit and accountability culture paradoxically drives out the trust that it claims to promote.

My first suggestion is simply to select rigorously and not to succumb to the temptation to appoint candidates who are simply not ready for such responsibility, merely in order to fill the position or to please either partner organization. A joint chair should not be the 'training wheels' of an academic career. Second, the sponsoring university and hospital or service must agree on mutually acceptable, synergistic and realistic aims and goals for the position. These aims and goals should be 'focused but roomy', allowing the professor to develop their own approaches, philosophies and research programme within the parameters of the KPIs. For example, broad aims that the joint chair will develop research capacity, undertake research and strive to win competitive research funding are perfectly reasonable. Insisting that the professor do this in a particular way, for example, by undertaking primarily action research, hermeneutic phenomenology, practice development or clinical trials, according to others' personal biases or agendas, is as nonsensical as it will be counterproductive. Third, there should be a realistic formal reporting system whereby the joint chair-holder regularly keeps the various parties updated about activities, achievements and outcomes. The agreed aims and goals of the position and mutual KPIs can be the framework for such reporting. Such a formal reporting meeting will be helpful perhaps every 6 months. The temptation to expect to meet with the joint chair every week or two should be resisted. If a manager and has a pressing need to meet weekly or fortnightly with the joint chair then they are not ready to have a joint chair. Fourth, there should be good, direct channels of informal communication but the joint chair holder should not sit under any kind of hospital/service line

management structure. This position needs to be insulated from any potentially distracting or damaging effects of 'executive churn' (Jones *et al.* 2008, Self 2009) or undue management pressure. Fifth, the new position should not be doomed at the outset by allocating no support. It should be accompanied by dedicated administrative support, such as a minimum 0.6FTE secretary/Personal Assistant, a Research Nurse or Research Assistant and an adequate budget to cover the essential start-up costs that any new research department or unit requires. Establishing a joint chair position is a significant, important organizational initiative and investment on the part of the university and hospital. It makes no sense to undermine this by underfunding it. Last (and this is perhaps the greatest leap of faith required on the part of university and hospital management), the process should be trusted and the professor left alone to do their job. This is a top level, senior academic position. If the selection process has been rigorous and carefully considered, then the successful applicant will be more than capable of being a self-starter, using their initiative, showing resourcefulness rather than always demanding resources, developing the role and their department in exciting and valuable ways, and meeting the aims and goals of the position. This is why the appointment is at professorial level. This is what the person has been hired to do, not to undertake the minutiae of another's agenda.

This is not management abdicating responsibility and lapsing into 'anything goes' laissez-faire. It is what Onora O'Neill (2002) calls the 'intelligent accountability' needed if joint chairs are to be enabled truly to serve the public and the profession:

Serious and effective accountability, I believe, needs to concentrate on good governance, on obligations to tell the truth and needs to seek intelligent accountability. I think it has to fantasize much less about Herculean micro-management by means of performance indicators or total transparency. If we want a culture of public service, professionals and public servants must in the end be free to serve the public rather than their paymasters. (O'Neill 2002, p. 6)

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References

- Apple M.W. (2005) Education, markets, and an audit culture. *Critical Quarterly* 47(1–2), 11–29.
- Cash K. (2009) The liberal nursing curriculum and the enterprise university. *Contemporary Nurse* 32(1–2), 105–108.
- Charlton B. (2002) Audit, accountability, quality and all that: the growth of managerial technologies in UK Universities Retrieved from <http://www.hedweb.com/bgcharlton/audit.html> on 29 August 2010.
- Darbyshire P. (2008) 'Never mind the quality, feel the width': the nonsense of 'quality', 'excellence', and 'audit' in education, health and research. *Collegian* 15(1), 35–41.
- Duke J., McBride-Hunter K., Walsh K. & Foureur M. (2009) The expectations of two New Zealand health services of the role of Clinical Chairs in nursing and midwifery. *Contemporary Nurse* 31(2), 129–141.
- Dunn S. & Yates P. (2000) The roles of Australian chairs in clinical nursing. *Journal of Advanced Nursing* 31(1), 165–171.
- Furedi F. (2004) *Where have all the Intellectuals Gone? Confronting 21st Century Philistinism*. Continuum, London.
- Gaita R. (2005) Callicles' challenge. *Critical Quarterly* 47(1–2), 40–52.
- Jones C., Havens D. & Thompson P. (2008) Chief nursing officer retention and turnover: a crisis brewing? Results of a national survey. *Journal of Health Management* 53(2), 89–105.
- Loughlin M. (2002) On the buzzword approach to policy formation. *Journal of Evaluation in Clinical Practice* 8(2), 229–242.
- Lumby J. (1996) View on Australian clinical chairs. *Contemporary Nurse* 5(1), 2–3. Retrieved from <http://www.contemporarynurse.com/archives/vol5/issue1/article/901/view-on-australian-clinical-chairs> on 29 August 2010.
- Ogilvie L., Strang V., Hayes P., Raiwet C., Andruski L., Heinrich M., Cullen K. & Morris H. (2004) Value and vulnerability: reflections on joint appointments. *Journal of Professional Nursing* 20(2), 110–117.
- O'Neill O. (2002) *A Question of Trust: Lecture 3, Called to Account*, Retrieved from <http://www.bbc.co.uk/radio4/reith2002/lecture3.shtml> on 29 August 2010.
- Power M. (1996) *The Audit Explosion*. Demos, London.
- Power M. (1997) *The Audit Society: Rituals of Verification*. Oxford University Press, Oxford.
- Self J. (2009) *Hospital CEO Turnover Could Hit 17%*, Retrieved from http://healthcarevoice.typepad.com/healthcare_voice/2009/04/hospital-ceo-turnover-forecast.html on 29 August 2010.
- Sparkes A.C. (2007) Embodiment, academics, and the audit culture: a story seeking consideration. *Qualitative Research* 7(4), 521–550.
- Walker K. (2009a) Curriculum in crisis, pedagogy in disrepair: a provocation. *Contemporary Nurse* 32(1–2), 19–29.
- Walker K. (2009b) Editorial: practice development: who cares and so what? *Journal of Clinical Nursing* 18(2), 157–159.
- Wallis M. (2007) Clinical chairs in nursing – mission impossible or fantastic journey? *Collegian* 14(2), 4.

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