Title

Shining a Light in a Dark Cave: The expectations of two New Zealand Health Services of the Role of joint appointment clinical chairs in Nursing

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Abstract

Clinical Professoriate positions within nursing in New Zealand are a relatively recent development. One New Zealand university worked collaboratively to establish two joint clinical Professorial appointments with different District Health Boards. Each position had unique mandates around research platforms, and differing operational responsibilities. This paper reports on the qualitative component of a larger study that aimed to examine the research culture, and the role of clinical chairs, within the two District Health Boards. This phase of the research involved semi-structured interviews with senior staff from the DHB to explore their experiences of working with the Clinical Professor. Themes that emerged revolved around expectations of the role during its development, and the subsequent perceived outcomes. The need for objective measures of the roles' impact on clinical outcomes emerged as a key impression from the participants, such measures will ensure the sustainability of the positions moving forward. Future research that focuses on measurements of outcomes attributable to the roles will ensure their sustainability over time.

> [The Clinical Professor is] part of the team that is going to shine the light in the cave to help us get out of the dark (153-154, P5).

Introduction

The Clinical Professoriate, a broad academic term most evident in medicine, is used to describe senior academics who take up roles in the service component of their disciplines, (Esperat, Green, & Acton, 2004). In nursing and midwifery in New Zealand and Australia it is used to describe senior academics who take up positions, often joint appointments, between a university and a nursing service institution (Cooney, Dignam, & Honeyfield, 2001; Dunn & Yates, 2000; Ellis, 2006; Lumby, 1996; Rowley, 1999).

Clinical Professorial appointments, in nursing and midwifery in New Zealand and Australia, are expressions of a wider international movement that has attempted to create a bridge between practice, education and research. The movement is also referred to as bridging the theory-practice gap.

In 2001 and 2003 respectively, the Graduate School of Nursing Midwifery and Health of Victoria University of Wellington established two clinical chairs in partnership with two District Health Boards (DHB). One of these appointments was part time (0.5 fte), and the other was full time. Both Professors were employed by the university and seconded to, and located within, the health service. In addition to the Clinical Chair appointments, the university was responsible for provided research assistance support to the roles. This paper reports on a research project that sought to explore the expectations, experiences

and future hopes of senior staff from two New Zealand DHBs in establishing Clinical Professorial appointments (Clinical Chairs) in nursing in partnership with one New Zealand university.

Background to the development of joint appointments and Clinical Professorial positions

Following the move of nursing education into the tertiary system, in the early twentieth century in North America, education became the primary issue of concern for nursing (Lynaugh, 2004). Lynaugh traces shifts in which educational institutions began to re-established connections with practice from the 1960s onwards, often in nursing faculty clinics. Faculty practice, although it had earlier beginnings, captured major attention in primary health care initiatives in the 1980s (Barger, 2004; Huttelmyer & Donnelly, 1996; Lantz, Reed, & Lewkowitz, 1994; Lynaugh, 2004). Major goals of its development were to bring education and practice into closer collaboration, to bridge what was becoming an increasing theory-practice gap, to provide leadership following the positioning of nursing and midwifery in academic institutions, and to foster a research culture within the DHB environment (Dunn & Yates, 2000; Emden, 1986; Happell, 2005; Lynaugh, 2004; Ogilvie et al., 2004; , Salvoni, 2001; Tamlyn & Myrick, 1995). According to these authors, a common understanding is that clinical practice in the service agency is enhanced by the closer collaboration and the fostering of research. Solvoni (2001) notes that leadership in research was the more recent addition to faculty practice goals. This recent addition of research is consistent with the focus in clinical professorial appointments using and producing available evidence and developing local projects (Dunn & Yates, 2000; Lumby, 1996; Rowley, 1999).

Advancement of research culture
Well established faculty-academic practice positions, particularly in clinical professorial positions and academic centres, foster the development of a research culture in the service organisation (Ament, 2004; Beitz & Heinzer, 2000; Dunn & Yates, 2000; Lantz, Reed, & Lewkowitz, 1994; Lumby, 1996; Rowley, 1999). In this context the professorial role includes identifying questions arising from issues in practice; assisting with proposal, grant, and report writing; and often providing research supervision of candidates undertaking postgraduate study. Attracting research funding for and mentoring of clinical staff in the development of chosen clinical projects is included in this work. Ament, Rowley and Crane (1989) affirm the promotion of centres of excellence in evidence based practice. Beitz and Heinzer (2000) and Lantz et al. (1994), further comments on the value of a researcher with a good grasp of the theory underpinning practice which enhances general clinical teaching in the professional development of clinicians. Therefore, faculty-academic practice and the role of clinical professors is a way forward for advancing the research skills, which are considered to be presently lacking in nursing and midwifery as well as and other social sciences (Butterworth et al., 2005). Nevertheless, a gap still exists in acknowledging scholarly activities in faculty-academic practice vis a vis traditional faculty appointments (Acorn, 1991).

Inter-institutional collaboration
A major factor regarding the success of faculty-academic practice and the clinical professoriate relate to formalised agreements between a service and academic organisations (Budden, 1994; Dunn & Yates, 2000; Lantz, Reed, & Lewkowitz,

1994; Saxe, et al., 2004; Williamson, 2004). Although different authors focus on different aspects of the collaboration, Lantz et al., (1994) discuss the commitment needed by administrators from both agencies such as their shared vision and values, common interests, channels for effective communication, as well as specific objectives relating to responsibility and accountability lines. Ogilvie et al., (2004) focuses on the difficulties encountered when those involved in the initial negotiations move to other positions and new personnel with difference sets of priorities take on responsibility for the initiative. These authors also describe the vulnerability of initiatives with no or inadequate administrative support. Chafetz, Collins-Bride, & White (2004) describe the time and issues involved in building up the collaboration; however, a significant challenge in this process can be a lack of a clear understanding of the position in the service agency (Dunn & Yates, 2000).

Success factors in launching into academic practice strongly relate to a number of infrastructural areas of the academic institution, known as 'readiness factors' (Lang & Evans, 2004). These include the centrality of the initiative in both the mission of the university and the nursing school, the availability of appropriate faculty and the provision of essential resources and support. Another success factor relates to the flexibility and clinical credibility the practitioner brings to the role (Ogilvie et al., 2004).

Role and career challenges
The personnel taking up faculty-academic practice have often struggled to create a balance through melding the two roles into one position. The two roles were often combined in an additive way rather than in an integrated way (Huttelmyer & Donnelly, 1996; Ogilvie et al., 2004). Even when academic and service components are reasonably well integrated there can be difficulty balancing the achievement of the threefold mission of education, client care and research (Saxe et al., 2004). Dunn and Yates (2000), when examining the clinical professoriate positions in Australia, found that direct involvement in client care was an aspect in only some positions. When this was absence, more time was available for research and political activities. Earlier, in Canada, Tamlyn & Myrick (1995) had called for faculty-academic practitioners to take on greater leadership in policy development to establish a greater impact on the political landscape of health. While the 'balancing act' for some incumbents meant experiencing the best of the worlds of practice and education, it also involved the worst of both these worlds (Beitz & Heinzer, 2000; Fairbrother & Mathers, 2004; Salvoni, 2001).

Sustainability
Concerns about the financial viability and sustainability of Clinical Chair positions were ongoing, often after a number of faculty-academic positions or centres received seeding grants (Dracup, 2004; Esperat, Green, & Acton, 2004; Ogilvie et al., 2004; Saxe et al., 2004). Maintaining financial sustainability with contracts from year to year was one particular difficulty. Ogilvie et al., further highlight the vulnerability for personnel after disestablishment of positions. According to these authors, disestablishment can occur when the emphasis is on the functional role rather than the overall vision. Within this focus on functionality, clinical agencies are often not able to appreciate the benefits to them, and believe there are greater benefits to the academic agencies. Dunn and Yates (2000) affirm that there can be greater benefits for academic institutions and that the output culture of service organisations operating within fiscal restraints make it difficult for them to justify

some initiatives. According to Dunn and Yates, it is important for academics to understand this type of service culture.

Capabilities of faculty-academic practitioners
High level skills in practice, education and research are important attributes of Clinical Chair positions. The importance of a faculty-academic practitioner's clinical credibility in embedding themselves, and the role, in the service organisation is also essential (Budden, 1994; Fairbrother & Mathers, 2004; Lantz, Reed, & Lewkowitz, 1994; Ogilvie et al., 2004; Williamson, 2004).

Clinical scholarship skills, a capability important for faculty-academic practitioners includes more than research skills (Fiandt et al., 2004). Clinical scholarship embodies the broad spectrum of work undertaken by these practitioners. It is an approach informed by ongoing questioning, reflecting and inquiring into every aspect of the process of their practice within the multiple partnerships in which they engage.

Other common capabilities needed in those in faculty-academic practitioners roles, and those who have organisational roles pertaining to them, are relational and communication skills (Acorn, 1991; Beitz & Heinzer, 2000; Dunn & Yates, 2000; Lantz, Reed, & Lewkowitz, 1994; Lumby, 1996; Martin, 1995; Sebastion, Mosley, & Bleich, 2004; Williamson, 2004). Most of these authors emphasise the importance of creating clear communication channels and fostering mutual respect at all level in the clinical service. Clinical Professors, are expected to demonstrate the general skills required as well as a range of more sophisticated skills (Darbyshire, Downes, Collins, & Dyer, 2004; Fiandt et al., 2004; Lumby, 1996; Sebastion, Mosley, & Bleich, 2004). These are summed up by Sebastion et al., as business entrepreneurship, leadership, collaborative resource development, innovator, mentorship, political savvy and creating an evidence-based climate. In addition, they are expected to model their own growth and assist the personal growth of others.

Study methods

This paper reports on the qualitative component of a larger study that aimed to examine the research culture, and the role of clinical chairs, in two DHBs within New Zealand. The larger study was a reflective evaluation that involved a survey that measured the research culture and the role of the clinical chair, and was disseminated to all Registered Nurses and Midwives employed by the two DHBs. In addition, semi-structured interviews were held with key stakeholders; this paper describes the findings that emerged as a result of these interviews. Ethics approval for this study was gained through the Victoria University of Wellington Ethics Committee.

In this component of the study eight senior staff, employed by the two health service partners, were interviewed about their expectations of the role of the clinical chair in their health service. The interviews also explored their experiences of working with the clinical chair, and their future expectations of the role. The participants included staff with a variety of senior roles including a Chief Executive Officer, General Managers, Directors of Nursing and those in other senior nursing role.

The audio-taped interviews were conducted by a research assistant using an interview guide to prompt discussion on the topics of interest; the interviews lasted approximately one hour. The interview guide questions focused on exploring the expectations that key-stakeholders had of the role during its establishment, core outcomes attributable to the Clinical Chair as well as thoughts about the future of the role within the organisation. Following the interviews the audiotapes were transcribed verbatim, they were then coded and anonymised. Analysis of the transcripts focused on content analysis, which drew on key words to develop consistent themes that explored the various experiences of working with a Clinical Chair in the New Zealand context.

Findings

Understanding the role of a Clinical Chair
Even though the two clinical chairs were established at different times, and in different ways (see introduction), all the participants believed that the establishment of the role was appropriate. One participant relayed the following narrative about the timing of the role's introduction to the health service:

> *We have a lot of medical professors, and yes, it was probably well overdue that we would have a nursing professor (30-3, P1).*

However, the historical understanding of what, or who, takes up a Clinical Chair role influenced how the organisation perceived the role. One participant, a senior DHB manager, also stated that the health service tended to equate the role of professor with medicine, which potentially restricts the expectations of how the role functions within an organisation.

> *We've got to actually start engaging or invading the psyche of Planning and Funding and the Board …that when [we] talk about a professorship we need to open it up and … say "does this need to be medicine or can it be across disciplines (87-90, P1).*

Two major issues the participants commented upon was the importance of getting the *right person for the right job at the right time (167-168 P4)* to fill the position and the degree of operational involvement the person should be expected to have. To this end, the participants were able to clearly articulate the expectations they had of the Clinical Chair role.

Expectations of the Clinical Chair role
All participants agreed that they consider that culture change was a major component of the role of the Clinical Chair. Whilst this term was most often in relation to the development of a nursing research culture, it was also used to describe broader expectations of wider health service cultural change.

> *My expectations were that it [the role of clinical chair] would raise the professionalism of nurses within the organisation and external to the organisation… lift our status in the national scheme of things and … [change] the research culture in the organisation (lines 82-86 P3).*

The clinical chairs were seen as having a role to play in assisting staff (especially senior staff) to question and reflect, rather than to rush towards doing. This was in part, expected to occur through the development of research-based programmes. As a result the expectation that the Clinical Chair would lead research-based programmes, which had a direct impact upon the synthesis of evidence into clinical practice, was a strongly articulated expectation of the role.

> *Have a clear leadership mandate around clinical effectiveness, research and evidence based practice and be supporting the organisation in its strategic direction (21-23, P5).*

The Clinical Chairs' expertise in research was considered to be a strength the positions would bring to the organisations. However, some participants had differing expectations around research with some expressing the view that the Clinical Chair should predominately "do" the research, whilst others held the opinion that the Clinical Chair ought to support others, including clinicians, to undertake research and become more research and evidence based practice minded.

Practice development, or at least practice innovation, was also valued by both organisations, and key stakeholders viewed this as being an example of the practical melding of academic rigor with the pragmatics of the clinical practice environment. The participants saw the Clinical Chair has having a role in the development of a culture of inquiry amongst nurses. This was often in relation to the implementation of evidence based practice, but was also strongly associated with a culture of development and innovation.

The participants also saw the Clinical Chair as having a part to play in the day to day governance of the organisation, but the degree to which they believed the person should be involved in operational matters differed (see discussion below), with some people expressing that too much involvement would "bog the person down". There were differing views on the degree to which the clinical chair should be involved in operational matters. As one senior manager stated:

> *We wanted the person to be leading the culture of research development… We did not want this person to get themselves involved in operational leadership, and we were very clear about that because it's been an error that's occurred in some other places (54-54 P4).*

In fact, the two Professors operated differently in regard to their operational involvement. One role was established so that the Professor was involved at a high level in clinical governance and planning, and was often sought out for advice but was not involved in any day to day operational matters, and had no operational line authority. The other role was established so that the Professor had a high degree of involvement in day to day operational matters, concern with staff development, and senior nursing management issues. There was however, consensus that, which ever model applied, a balance needed to be struck so that the incumbent did not get "bogged down" to the extent that they could no longer bring a different view to bare. They needed to have the space to think, reflect on practice, and support others.

Achievements of the role

Overall the participants believed the Clinical Chair role had met their expectations in raising the profile of nursing and midwifery within the organisation (including at CEO and Board level). One participant indicated that because of the achievements of the role within the organisation she was confident that the benefits would be sure to outweigh the costs associated with the position (131-132, P4).

All participants agreed that the incumbents had forged closer links with multi-disciplinary colleagues and had also built stronger bridges between the academic and practice community. All participants valued the practical and pragmatic approach of the incumbents and their ability to match academic rigor with the practical reality of the (often "cash strapped") clinical practice environment.

> *[Our Clinical Chair] is a person who sees what needs to be done and seeks a way for it to be done...[the Clinical Chair] is quite pragmatic about how it will be done...[as] we are quite resource constrained (78-80, P2).*

The role was also considered to have successfully raised the profile of nursing within the organisation as well as raise the profile of the organisation, both nationally and internationally. This was especially true in one of the DHB that saw itself, through the Clinical Chair, as a leader in practice development in New Zealand, and a collaborator in practice development research internationally.

> *[The Clinical Chair's] experience and background in practice development has been a huge benefit to the organisation... and... positioned us nationally. We are leading the way with practice development in New Zealand (38-40 P1).*

The role is seen as a position that is immersed and integral part of the successful functioning of the DHB. Participants also perceive the role of the Clinical Chair was a generic rather than a specialised role, and as a result was able to respond to a variety of situations appropriately. An additional strength was the Clinical Chair's ability to work across the hospital and the wider DHB. The Professors have the ability to liaise with all levels of DHB staff, and build collaborative relationships with colleagues of other disciplines, especially medicine.

> *...in the real world of practice and the issues that confront us every day... a position that works practically with us on practical things (284-289, P8).*

Despite the participants' expectations in relation to how the role should operate within the organisations, they were all in agreement that a key aspect of the success of the current incumbents was attributable to their interpersonal skills. It was evident that a key factor in the roles' success, in addition to clinical and academic credibility, was the excellent communication skills possessed by those employed into the Clinical Chair positions.

> *The person in this role wasn't this person who was untouchable... the person doing the role needs to be a personable person, have a sense of humour and talk in words we can all understand (168-177 P3).*

In addition to these broader issues, the participants also relayed that there had been a greater uptake of graduate-level study, which they attributed to the presence of the Clinical Chairs in the practice environment. They believed the approachability and visibility of the incumbents, in addition to the way they were willing to engage and support staff who had ideas about research and innovation, or who were contemplating undertaking future study, contributed to this.

The participants saw the role as making a tangible contribution to best practice and the care of patients. They valued the neutrality of the role and differing perspectives that the incumbents brought. They also believed that both Clinical Chairs had made a significant and positive contribution to the development of a positive practice culture, a culture of effectiveness, and research mindedness. However, most of the participants believed this had been due to the recognition of the incumbents that the role of the Clinical Chair needed to expand and be supported by a team. Both professors had actively sought to develop a team or unit to support the work and both had sourced funding to achieve this from a variety of sources. As one participant put it, the role has "*expanded and taken on a life of its own - it's a living happening thing*" (113, P7). The accomplishments the role had achieved lead to expectations about the future of the role within the organisations.

Future expectations
The participants were all able to articulate expectations about how the roles would function in the future. The participants envisioned that the role, and the research units the Clinical Chairs' had founded, would continue to grow. In part, through attracting more funding for research and evidence-based activities, including practice development. Similarly, all participants felt that the chairs had been successful because of what they had achieved during their tenure. One participant remarked that it was not until the role existed that it became obvious how much it was needed.

Participants also expressed the view that the role had provided a template for the development of other Clinical Chair positions within their institutions. Suggestions were made on the development of roles that specifically focused on areas such as midwifery, aged care and mental health. This has the potential to lead the way for the development of new joint roles, though not necessarily at professorial level.

Another key aspect of the Clinical Chair's success in the role rested on the nature of the institutional collaboration. It is important that open communication, and the articulation of a joint vision and subsequent goals for the role are an integral aspect of developing the role. These early discussions are crucial to the success of the role in the long term, as it defines the scope and responsibilities of the position. The participants were also able to articulate why this role definition was a key factor in the role's success.

> *The reason that the professor role has been a success is that we have a very easy and supportive relationship with [the] university. We were quite clear from the start …what we both wanted from the role…we set those boundaries quite early… If you've got a mature, supported trusting relationship it allows the [Clinical Professor] the freedom within their role*

to actually… produce the goods, and at the end of the day that's what it's about (99-117, P1).

One of the expectations of the roles in the future was around the monitoring of effectiveness attributable to the Clinical Chair roles functioning within the organisations, especially in relation to enhanced clinical outcomes.

My expectations would be that concrete outcomes start occurring clinically that improve nursing improve nurses' practice and improve the outcomes for patients… [outcomes] that are concrete and tangible (315-318 P3).

Participants at both sites expressed the view that they would like the role (and the units the incumbents founded) to continue. One participant offered the following narrative describing how the Clinical Chair role was perceived as an integral aspect of governance within the DHB, and envisioned that in time the role of clinical chairs would be expanded.

Continuing with the role [is important]… fundamentally I think it is part of the organisation that we can never step back from … my expectation for the future is … one person can't do everything … [we] need to multiply the Professor of Nursing people at some stage (61-63, P1).

Discussion
The fostering of well established clinical professorial positions and academic centres, has been demonstrated to foster the development of a research culture in the service organisation (Ament, 2004; Beitz & Heinzer, 2000; Dunn & Yates, 2000; Lantz, Reed, & Lewkowitz, 1994; Lumby, 1996; Rowley, 1999). This evaluation further supports the validity of Clinical Chair roles in the development of research cultures within the New Zealand setting. This occurs, in part, through platforming research within the organisation, which has significant impact on both clinical scholarship and practice development.

This research study confirms that the participants had the expectation that client care would be enhanced as a result of having a Clinical Chair in place; despite this, some of the participants struggled to articulate tangible evidence of enhanced care, focusing instead on the practicable advice and accessibility offered by the Clinical Chair. However, several authors cite enhancement of client care as a general outcome of joint appointments (Acorn, 1991; Ament, 2004; Huttelmyer & Donnelly, 1996). Clinical innovation and modelling of clinical excellence are pivotal to such outcomes (Darbyshire, Downes, Collins, & Dyer, 2004; Gilliss, 2004; Sebastion, Mosley, & Bleich, 2004); these factors however, can be difficult to measure. It is also important to recognised that complex contextual issues can hinder the promotion and development of evidence based practice even though personnel of the clinical professoriate are well situated to advance it (Rowley, 1999).

The participants in this research clearly acknowledged the benefits of the Clinical Chair's advanced clinical scholarship skills. Such skills incorporated the development of a culture of inquiry amongst nurses, with a focus on evidence-based practice and practice innovation. The need for such skills within clinically-focused organisations has also been recognised in the literature as an important

feature of Clinical Chair positions (Fiandt et al., 2004). To achieve this it is crucial that those in Clinical Chair positions have the time needed to question, reflect and inquire into every aspect of clinical practice within the varied context in which they engage. Based on this evaluation it is best if the positions, and associated research units, operate from within the organisation but independently from the organisational structure. This flows from clearly articulated boundaries around the role's operational responsibilities; minimising operational involvement assists to enhance a Clinical Chair's ability to engage in critical reflection and challenge traditional approaches to addressing clinical issues. In addition, this should assist to reduce the recognised gap between perceived scholarly activities in faculty-academic practice versus traditional faculty appointments (Acorn, 1991); thus, ultimately supporting the university's focus on academically-credible outcomes.

The enhanced profile of the organisation, according to the participants, was an unforseen benefit of the Clinical Chair position. One DHB in particular relayed how they were now positioned as a leader in practice development both nationally and internationally because of the leadership provided by Clinical Chair on this issue. This was considered to be significant and tangible achievement of the role. It is interesting to note that the Clinical Chair in this DHB was employed full time, and had less administrative responsibilities than his counterpart. This lack of organisational responsibility is considered to be a key aspect of the successfulness of the position, as it has enabled the incumbent to focus on advancing clinical scholarship as well as producing tangible outcomes attributable directly to the role.

Another aspect that had a significant impact upon the role of the Clinical Chair is the support they receive from the organisation's leadership. A key aspect of the success of these roles is the level of support they receive from the Director of Nursing (DON) in the associated DHB. In establishing like positions it is important to assess what vision the DON has for the role, as this impacts significantly upon what the role can achieve. For example, one DHB featured in this study has a specific mandate around a research methodology, which has fostered a very successful research platform that has been able to demonstrate enhanced clinical outcomes. This mandate stemmed from a joint vision that was clearly established by the both the DON and Clinical Chair from the outset of the position's establishment. To this end, it is also important that the Head of School from the University is prepared to let the incumbent develop the position in a way that is fostered from within the DHB. As previously highlighted, the importance of a faculty-academic practitioner's clinical credibility in embedding themselves, and the role, in the service organisation is an essential aspect of the role's success (Budden, 1994; Fairbrother & Mathers, 2004; Lantz, Reed, & Lewkowitz, 1994; Ogilvie et al., 2004; Williamson, 2004)

Another key aspect that emerged from this research was the need for good communication between the DHB and the University around the purpose of the role within both organisations. These negotiations should occur at the conception phase of the role's establishment, which means that from the outset the understandings of what the role's focus is are clear. This also means that appropriate measurements of the role's success can be effectively targeted.

Improving collaboration and communication between education and service organisations is an important outcome for Clinical Chairs because a major

motivation for establishing faculty-academic positions was the bringing together of nursing education and practice, and more latterly research. The Clinical Chair positions described in this evaluation were focused on these aspects of scholarship. Previous research has indicated that enhanced scholarship stems directly from the inter-institutional collaboration, and ultimately results in increased numbers of students undertaking postgraduate education (Acorn, 1991; Ament, 2004; Budden, 1994; Fairbrother & Mathers, 2004; Humpheys, Martin, Roberts, & Ferriti, 2004; Lang & Evans, 2004; Lantz, Reed, & Lewkowitz, 1994; Ogilvie et al., 2004; Saxe et al., 2004; Tamlyn & Myrick, 1995). Such outcomes are significant for the students themselves, but equally important for both the clinical and educational agencies. Furthermore, Ogilvie et al., observed better recruitment of graduates into clinical areas where faculty-academic practitioners and Clinical Chairs worked.

Research also indicates that students and clinical staff appreciated the clinical competence and credibility of faculty-academic staff, who not only facilitated greater linkages between theory, practice and research, but provided staff development and promoted greater understanding of the mentoring and the educational role of clinical staff (Ament, 2004; Budden, 1994; Fairbrother & Mathers, 2004; Humpheys, Martin, Roberts, & Ferriti, 2004; Lang & Evans, 2004; Lantz, Reed, & Lewkowitz, 1994). This research has highlighted that the senior staff who participated in this study also appreciated and recognised the extensive skill-base held by the Clinical Chair, and the contribution they made to the clinical learning environment. However, moving forward the ability to reliably measure outcomes, attributable to the Clinical Chair position, is considered by the participants to be an important contributor to the roles sustainability in the long term.

The issue of the sustainability of Clinical Chair positions is often highlighted in the literature (see Dracup, 2004; Esperat, Green, & Acton, 2004; Ogilvie et al., 2004; Saxe et al., 2004). Based on the findings of this evaluation this may, in part, be addressed through clearly articulated mandates for the roles. In part, this would occur because the mandate would remove any ambiguity around the role in relation to measurement of outcomes. For example, in this research one DHB expected the Clinical Chair role to focus on practice development, this focus resulted in quantifiable outcomes for the DHB as described by the participants narratives.

This research has evaluated senior staffs' experiences of the establishment of Clinical Chair positions from two DHB in New Zealand. The research method employed for this aspect of the research was semi-structured interviews, and although the generalisability to other clinical Chair positions, the findings support the previous literature on the establishment of such roles. Future research conducted in the New Zealand context needs to focus on measuring formal outcomes of the roles' impact on clinical outcomes.

Conclusion
This is the first study that has sought to evaluate the role of Clinical Chair positions within the New Zealand context. This qualitative findings of a study explored the expectations, experiences and future hopes of senior staff from two New Zealand DHB in relation to the establishment of Clinical Professorial appointments. The findings indicate that that the clear articulation of a joint

vision for the Clinical Chair position between the DHB and University is crucial to the success of the role. Future research needs to focus on measurable outcomes that can be attributed to the Clinical Chair position to ensure it's sustainability over time.

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