Graduate School of Business

The Clinician Manager in Rural Western Australia: A Sensemaking Perspective of the Role

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Declaration

This thesis is my own work. No part has been submitted for a degree at this or any other university.

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Abstract

Economic, political and social forces are driving the implementation of reforms in health service systems worldwide. As the health industry concentrates on ways to improve operations and to achieve overall cost effectiveness, health service organisations are developing and implementing structural changes to address issues of cost containment, utilisation and resource allocation. One approach has been to devolve resource allocation and utilisation decisions to the program or unit level. Clinical practitioners have been required to assume general management responsibilities in addition to their clinical role. A new type of clinician, the clinician manager has emerged to take on this task. Despite the trend towards the clinician manager role in many sections of health care world wide, there is little research in the area and a poor understanding of the experience of the role.

The aim of this research was to explore clinician managers' perceptions of their experiences in their adaptation to and their enactment of the new role. The study was based in the symbolic interactionist paradigm. Sensemaking, the process by which individuals ascribe meaning to the events in their environment, provided a theoretical context that directed the inquiry. Grounded theory was the methodological approach. The research sample was made up of Directors of Nursing/Health Service Managers, a clinician manager role that had emerged from the restructuring of rural health services in Western Australia. Data was gathered from in-depth interviews.

Findings suggested that sensemaking was influenced by structural and personal elements. Structural elements were created by the stakeholders, individuals and groups who relied on the clinician manager for the achievement of their goals but upon whom, in turn, the clinician manager relied upon for their support and cooperation. The sensemaking process of the clinician manager was mediated by the interaction with the stakeholders — the most influential factors being the clinician manager's perceptions of the trustworthiness of the stakeholders, the political behaviour that characterised the interactions with the stakeholder and role stress. In particular, role conflict, role ambiguity and role overload emerged. Personal elements were the personal characteristics of the clinician manager — the most

salient being the experience of role strain, self-efficacy (i.e. their belief in their ability to do the job) and their commitment to the sensemaking process.

Circumstances in the environment constrained their reliance on others for validation of their explanations of events and the actions they took. Most made decisions based on intuition and "gut feeling" — validating these decisions with subjective evaluations of outcomes and retrospective explanations. These processes were further mediated by the characteristics of the individual, particularly perceptions of self-efficacy. The ways in which the clinician managers adapted to and interpreted their role was diverse, which made the role more an expression of individual preferences than a coherent part of a larger organisational structure. Findings indicated that the clinician managers relied on their sensemaking processes in order to explain the ambiguous nature of their practice environment and to plan actions within the context of a role that was poorly defined by the organisation.

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Operational Definitions

Clinicians

Those who have a professional qualification and registration and whose practice involves direct patient care in the health service industry. The term is generally applied to medical practitioners, nurses and allied health professionals such as therapists (Alexander, 2000).

Clinician Managers

Clinicians who, in addition to their clinical practice, assume general management responsibilities. Individuals are formally responsible for management activities and are actively engaged in the provision of client services (Cohler and Kaluzny, 1988).

General management

General management is a broadly based concept but entails responsibility for the management of others beyond that of the professionally based clinical group and includes accountability for the performance of the employing organisation in terms of efficiency and effectiveness (Eastman and Fulop, 1997)

Sensemaking

The process by which individuals ascribe meaning to the events in their environment (adapted from Weick, 2001)

Organisational Definitions and Abbreviations

DON (Director of Nursing)
Responsible for the management of the nursing service and the overall responsibility for clinical nursing. Manages the health service in association with the HSM

DON/HSM (Director of Nursing/Health Service Manager)
A clinician manager role created by amalgamating the DON and HSM role

GM (General Manager)
A public service employee who is the principal accounting officer for the corporate management of the health district

GP (General Practitioner)
A medical practitioner in private practice who has admitting rights to a health service under a contractual agreement

HDWA (Health Department of Western Australia)
The state government department responsible for the delivery of health services in the public sector

Health care site
Any clinic, hospital, nursing post, community-based health care service or other establishment where health services are delivered.

Health district
A number of health services under the auspices of a GM

Health service
A number of health care sites normally including a hospital, community nursing service and nursing post but which may include other establishments where health services are delivered. The DON/HSM is responsible for the management of the health service.

HSM (Health Service Manager)

A non-clinical role with responsibility for the general management of a health service. The HSM manages the health service in association with the DON.

Definitions of Nursing Positions

The following are definitions of nursing positions within the Western Australian public sector. Those relevant to the discussion relating to this research are included. Definitions are from the NURSES' (ANF – WA PUBLIC SECTOR) AWARD 1994 [N0103] pages 59–61.

Registered Nurse means a person whose name is entered in Division 1 of the register of the Nurses' Board of Western Australia.

Registered Nurse Level 1 means a registered nurse who holds a current practising certificate, provides direct patient care within a nominated area of a health care site where there is access to a higher level of clinical nursing expertise and is responsible (where applicable) for the clinical supervision for enrolled nurses.

Registered Nurse Level 2 – Clinical means a registered nurse who holds a current practising certificate and any other qualification required for working in a particular field of nursing. Such a nurse is responsible for direct patient care, the clinical management of a nominated area within a health care site and for clinical supervision of nurses at Level 1 and/or enrolled nurses.

Registered Nurse Level 3 – Clinical means a registered nurse(as defined) who holds a current practising certificate and any other qualification required for working in a particular field of nursing. Such a nurse provides clinical expertise and is responsible for the standard of nursing care in a nominated area (or areas) within a health care site. Such a nurse may be responsible for direct client/patient care of a specific caseload.

Registered Nurse Level 4 – Clinical means a registered nurse who holds a current practising certificate and any other qualification required for working in a particular field of nursing. Such a nurse provides advice/resources for nursing clinical practice and is responsible for the planning, organising, implementation and evaluation of clinical practice within a nominated health care site, district or region.

Registered Nurse Level 5 means a registered nurse, other than a Director of Nursing employed in a teaching hospital, who holds a current practising certificate and any other qualification required for working in a particular field of nursing. Such a nurse has overall responsibility for clinical nursing, nursing management, education and — where applicable — research for a nominated health care site, district or region.

Chapter 1: Introduction

1.1 Background to the research

Recent times have seen considerable change in the health care industry, with numerous forces driving that change. (Bloom, 2000; Issel and Anderson, 1996). The World Health Organisation (1994) identified a number of factors that are driving change in all parts of the world. These factors include cost constraints, an ageing population, the impact of technology, increased consumer knowledge with a concomitant desire for better health outcomes, and changes in the health task from acute to chronic conditions. Economic, political and social forces are driving the implementation of reforms in health service systems worldwide. Australia is no exception.

While the aim of health reforms are claimed to make the system more responsive to user needs, most are really designed to bring its component parts under control — particularly financial control (Glouberman and Mintzberg, 2001). For these reasons, the health industry has begun to concentrate on ways to improve operations and achieve overall cost effectiveness (Thorngren and Tinstman, 1990). Health service organisations have developed and implemented structural changes to address issues of cost containment, utilisation and resource allocation (Leatt, Sharkey, Zagar, and Meslin, 1991).

The restructuring of health service organisations in an attempt to address complexity and to better integrate services in order to reduce costs has been a recurrent theme. One approach has been to devolve resource allocation and utilisation decisions to the program or unit level. Under this structure, and in an attempt to increase efficiency, clinical practitioners have been required to assume general management responsibilities in addition to their clinical role. The belief was that by altering organisational structures in this way, clinicians who were previously responsible only for patient care decisions would now participate in controlling costs (Meslin, Lemieux, and Wortley, 1997). Some have also viewed this as —

not only a way of managing costs better — but also as a strategic weapon with which to curb the powers of overly independent clinical professionals (Exworthy and Halford, 1999). The move, however, is not without uncertainties.

The antagonistic relationship between clinical professionals and health services is a recurrent theme in the literature (Glouberman and Mintzberg, 2001), and resolving this conflict in the context of one role may create unexpected consequences for the organisation and the individual in the role. It has been suggested that delegating management decision making to clinicians may put them in a situation of conflict with their professional commitment to provide each individual patient with the highest quality of care (Veatch, 1991).

Alternatively the view may be taken that clinicians are in the best position to allocate limited health care resources in a rational and humane way (Meslin et al., 1997). This coming together of roles involves the intermixing of two separate cultures and views of the world, often following a long tradition of disagreement (Fitzgerald and Sturt, 1992). Nevertheless, a new type of clinician, the clinician manager has emerged to take on this task. Uniquely, the clinician manager combines direct and current clinical practice with management practice to take decisions about the range and quality of health care services offered. Although this new role may herald new patterns of compromise and collaboration between managers and health care professionals, it is a major undertaking.

Despite the trend to the clinician manager role in many sections of health care world wide, there is little research in the area and a poor understanding of the experience of the role. Sensemaking (Weick, 2001), the process by which individuals ascribe meaning to the events in their environment, provided a theoretical context that directed such an inquiry.

In public-sector rural health services that are under the management of the Health Department of Western Australia, a model of the clinician manager has been adopted. As part of the restructuring of rural health services — and in keeping with the defined aim to develop managerial responsibility with defined accountability and the removal of any

administrative overlap (Rural Health Policy Unit, 1994) — the management of rural and remote health services was rationalised. Traditionally, these services were managed by an administrator (who was responsible for the general management of the health service) and a director of nursing who was responsible for the management of the nursing services. Following the restructuring and the implementation of district management, the administrators were removed and the director of nursing assumed all general management responsibilities in addition to previously held clinical management responsibilities. The new position created was known variously, but generally as Director of Nursing/Health Service Manager or DON/HSM.

The focus of this research is the DON/HSM job as an example of the clinician manager role.

1.2 Research aims and objectives

1.2.1 Research question

What are the sensemaking processes of the clinician managers in rural Western Australia in their adaptation to the new role?

1.2.2 Research aims

The overall aim of the research was to explore clinician managers' perceptions of the experience of adaptation to and the enactment of the clinician manager role.

1.2.3 Research objectives

From the perspective of the clinician manager the seven objectives were to:

1. Identify expectations of the role in the context of previous experience;
2. Describe surprises encountered in the role.
3. Identify cues for sensemaking extracted from and acted upon in the environment and the process of change in personal schemas.
4. Investigate the social processes involved in attributing meaning to the role.

1.4 Methodology

The study was based on the symbolic interactionist paradigm (Mead, 1934) and used sensemaking (Weick, 1995) to focus the inquiry. Qualitative methods were employed, and grounded theory was the methodological approach. This approach systematically applies specific procedural steps to ultimately develop a grounded theory — a theoretically complete explanation about the particular phenomena (Streubert and Carpenter, 1995).

The foundations of grounded theory (Glaser and Strauss, 1967) are theoretical sampling, (a process that is controlled by the emerging data) and constant comparison — a method for joint data coding and analysis. Qualitative methods were selected as the elements of symbolism, meaning and understanding that the research explored. These methods required consideration of the individual's own perceptions and subjective concerns. It was considered essential to the research that the informant, rather than the researcher, defined the work environment.

1.4.1 Research sample

Given the exploratory nature of the research and the symbolic interactionist framework (Blumer, 1969), the nature of the research was considered to be contextual. The research sample was selected to minimise variation and to maximise homogeneity in order to describe the role enactment process in as much depth and detail as possible. The samples were chosen more for their access to the phenomenon, rather than their representativeness.

The selection of the sample became one of elimination. First, the sample was limited to one clinical group; namely, nurses and then to one context — rural hospitals. The research population then became DON/HSMs in rural hospitals in Western Australia. The sampling strategy can be best described as criterion sampling (Creswell, 1998) where all cases met the criterion of being appointed to the DON/HSM position.

When this research began in August 2000 there were less than 50 rural health services in Western Australia that had a DON/HSM position. Most of these were in the south-west of the state. The small population that met the criterion for inclusion constrained theoretical

sampling, an essential component of grounded theory. Theoretical sampling is sampling on the basis of concepts that have proven theoretical relevance to the evolving theory (Strauss and Corbin, 1990). Theoretical sampling requires the initial selection of a homogeneous sample and then, in the light of developing theory, pursuing further selected samples in order to confirm or refute the conditions, both contextual and intervening, under which the model holds (Creswell, 1998). As explained in Chapter 4, the DON/HSMs in rural health services in Western Australia became both the sources of the data and the means by which the emerging theory was substantiated.

The research was conducted in twelve health districts. Figure 1.1 shows the districts and their geographical relationship to the regional centres: Bunbury, Geraldton and the Perth metropolitan area. Thirty-six interviews were conducted for this research.

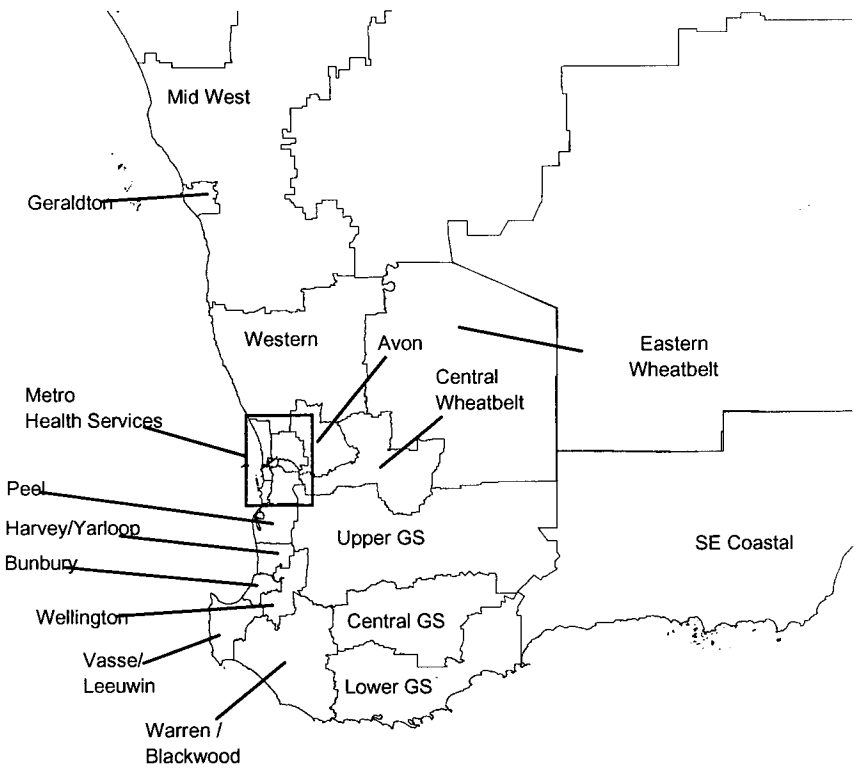

Figure 1.1: Health services in the south-west of Western Australia

1.4.2 Data collection

Data was gathered from in-depth interviews. Interviews play a central role in data collection in a grounded theory study and are considered an excellent way of discovering the subjective meaning and interpretations that people give to their experiences (Denzin and Lincoln, 1994). In addition, they allow social processes and negotiated interactions to be studied that could not be studied in any other way (Daly, Kellehear, and Glicksman, 1997). Each interview was audio taped and enhanced with field notes.

Interview design

The interviews, in the main, were unstructured with some set demographic questions as suggested by Marshall and Rossman (1999). A list of key concepts were developed, drawn from the sensemaking process as identified by Weick (1995) and designed to meet the defined objectives of the research. These key concepts were used to guide the interview in terms of raising issues to be discussed. This allowed some comparison between individual informants. The focus of the interview was the symbolic processes, actions, phases, rituals or stories that provide unfamiliar circumstances with coherence and understanding (Greenberg, 1995).

Data analysis

The interviews were transcribed verbatim from the audio tapes. These data were managed using NVivo software, which assisted in the analysis of the data. NVivo provides a range of tools for handing data records and information about them for browsing and enriching text, coding it visually or with categories, and annotating and accessing data records (Richards, 1999).

The analysis of the data was shaped by grounded theory and used the coding procedures articulated by Strauss and Corbin (1990). The first step was open coding, where initial categories of information about clinician managers' adaptation to their roles were identified. The coding evolved as categories were revised, added to, merged, deleted and renamed as understanding of the data changed, following the method of constant comparison (Glaser and Strauss, 1967). The understanding of the data at any one given time, shaped the next interviews. Following the achievement of theoretical saturation

(Glaser, 1992; Glaser and Strauss, 1967; Strauss and Corbin, 1990), further interviews were conducted to add to the richness of the description of the categories and to contribute to the verification of the data. Demographic data were also recorded.

This open-coding stage was followed by axial coding — a technique by which data are put back together after open coding by making connections between the categories. A modified version of the paradigm model proposed by Strauss and Corbin (1990, p. 99) was employed in this process. A modified conditional matrix (proposed by Strauss and Corbin, 1990) was also employed to organise and explain the data. The remaining data were organised into sets and case-node sets that were considered to describe the data in the most logical and coherent way and best represented the experience of the DON/HSMs. These sets formed the basis of the narrative explaining the findings of the research.

1.5 An outline of the thesis

Chapter 2 overviews the context of the practice of the DON/HSMs, describing issues in health care delivery in rural areas and the relevant structural components of the Health Department of Western Australia. Chapter 3 builds the theoretical foundation upon which the research is based by reviewing the relevant literature. Chapter 4 describes the methodology used to collect the data that was used to answer the research question and the approach taken to the analysis of the data. Chapters 5 and 6 present patterns of results and analyses them for their relevance to the research question. Chapter 7 reports on the conclusions drawn from the findings and describes implications for further research as well as policy and practice.

This chapter introduced the research problem and identified the context in which it would be investigated. The aims and objectives of the research were identified then the research was justified, the methodology briefly described and the thesis outlined. On these foundations, the thesis can proceed with a detailed description of the research.

Chapter 2: The practice environment of the DON/HSM

2.1 Introduction

In order to understand the role of the DON/HSM, it is necessary to review the issues in their practice environments. This chapter discusses issues relating to the delivery of health care services in rural and remote areas of Australia and describes the development of the clinician manager role within the context of public health services in rural Western Australia.

2.2 Rural and remote Western Australia

Western Australia covers an area of 2,527,517 km^2, 99.8% of which can be considered rural or remote. 27.9% of the total population of 1,726,095 (1996 census Glover, Harris, and Tennant, 1999) live in rural or remote areas. Rural and remote areas can be defined in terms of classification systems.

The Rural, Remote and Metropolitan Areas classification (RRMA) (Department of Primary Industries and Energy and Department of Human Services and Health, 1994) is a classification based on statistical local areas (SLAs), related primarily to population numbers and an index of remoteness. The index of remoteness is calculated using the distance to an urban centre containing a population of over 10,000 people or more and population density. The structure of the RRMA is shown in Table 2.1.

Table 2.1: Structure of the RRMA classification (Strong et al., 1998)

Zone	Category
Metropolitan zone	Capital cities
	Other metropolitan centres (population ≥ 100,000)
Rural zone	Large rural centre (population 25,000–99,000)
	Small rural centre (population 10,000–24,999)
	Other rural areas (population < 10,000)
Remote zone	Remote centre (population ≥ 5,000)
	Other remote areas (population < 5,000)

Using this classification, Western Australia does not have any large metropolitan centres apart from the capital city, Perth, nor does it have any large rural centres. This method for allocating a statistical local area to a rural or remote area is not perfect (Strong et al., 1998) and there can be considerable population variance within an SLA. It does, however, demonstrate that Western Australia has very large, sparsely populated rural and remote areas supported by only one large metropolitan centre. The difficulties of delivering health care services to the rural and remote areas of Australia are likely to be more problematic in Western Australia.

2.3 Health in rural and remote areas

People living in rural and remote Australia have many health disadvantages compared with urban counterparts, which is demonstrated by higher mortality and morbidity rates for some diseases. Strong (1998) examined the range of indicators of health status across RRMA categories for the 1992–96 period and reported that these differences included:

- Male and female death rates for those living in capital cities were 6% lower than for those living in large rural centres and 20% lower than for those living in remote centres.
- Injury is a major contributor to premature mortality in Australia, and there is a strong pattern of increasing mortality from injury with increasing remoteness, particularly for males.

- Death rates from all causes of injury to males living in "other remote areas" were double those of males living in capital cities.
- Males living in "other rural areas" experienced death rates from injury that were around 50% higher than those living in capital cities.
- Death rates from road vehicle accidents show even more pronounced patterns of increase with increasing remoteness.
- Both males and females living in "other rural areas" die in road vehicle accidents at more than double the rate of those living in capital cities.

Hospitalisation often follows the same pattern as mortality. Similar patterns include:

- Hospitalisation rates for injury are much higher in rural and remote zones compared to metropolitan zones.
- Hospitalisation rates for falls in people aged 65 years or more show higher rates in rural and remote zones.
- Male hospitalisation rates in the remote zone due to burns were seven times those of males living in capital cities.
- Both males and females living in the rural zone experienced one-third higher hospitalisation rates from burns than those from in capital cities.

These higher rates of morbidity and mortality in rural and remote areas may be attributed to a number of factors:

- The geographic isolation creates problems for the access to care.
- There is a shortage of health care providers and health services. The supply of medical officers and pharmacists fall sharply in rural and remote zones, with nurses providing a much higher proportion of the health care than would be expected in metropolitan zones.

- Socioeconomic disparities have been identified. There is a general pattern of socioeconomic disadvantage as population density declines. Socioeconomic wellbeing has been reported to have a strong association with the health status of the population.
- There is a greater exposure to injury, particularly for people employed in farming and mining.
- Lower road quality increases the motor vehicle accident rate.
- There is a higher indigenous population in rural areas. Australia's indigenous populations continue to experience much poorer health across all indicators of health status than other Australians.
- Health related behaviour associated with higher alcohol consumption and higher incidence of smokers is a feature in remote zones.

(Glover et al., 1999; National Rural Health Policy Forum and National Rural Health Alliance, 1999; Strong et al., 1998)

Models of care in rural and remote areas also differ. Requirements for travel for patients and health care providers result in higher use in some areas of health care and lower use in others (Reid and Solomon, 1992). For example, there may be a lower rate of general practitioner (GP) consultations and higher rates of hospital in-patient care because travel to the GP may be further than to the nearest hospital. Similarly, patients with chronic conditions that require follow-up treatment are more likely to be hospitalised in rural and remote areas, especially if they have long distances to travel in order to seek care.

Managers of health services in rural and remote areas face issues that are different to those that would be expected in metropolitan zones. Rural areas offer a unique context for practice. The necessity for management practices that support quality service provision is critical if the service models that reflect the special needs and circumstances of rural areas are to succeed. Managers and organisations need to be continually improving skills and knowledge to sustain the services. Despite this need and the growing body of literature regarding rural health (see, for example, the Australian Journal of Rural Health), the focus

of this literature tends to be clinical practice and policy issues. The management of health services at the provider organisation level appears to have been overlooked.

2.4 Health services in rural Western Australia

Health services in rural and remote Western Australia are provided almost entirely by the public sector. The Health Department of Western Australia (HDWA) is responsible for the operation of a network of health service delivery units across the State, ranging from community nursing services to large teaching hospitals in the metropolitan area. In the rural area there are nine major regional public hospitals and a further 68 smaller hospitals.

These smaller hospitals range in size, facilities and types of communities they serve and the geographical conditions they experience. There are long established farming communities that have many hospitals, typically built with community funds after World War 1 and again after World War 11. Such areas, often associated with a railway line, can have towns every 100 kilometres, with many towns having hospitals. The hospitals can be small, with less than ten beds, and whose main in-patient population is nursing-home type patients. There are small but busy hospitals with 15–25 beds for people who need medical care. Medium sized hospitals (up to 50 beds) provide obstetrics and some surgical services, and treat medical patients and many of the emergency patients from the surrounding district. Larger regional or base hospitals undertake complicated obstetric services, a range of surgical procedures, treat complex medical and psychiatric conditions, and receive emergency patients.

Many of the smaller hospitals in rural and remote areas essentially only offer emergency services and care for older people who need nursing care. Nursing home type patients may live in the hospital for extended periods, often waiting for a place in a nursing home in a nearby town. The role of some hospitals has changed over the past 10–15 years as clinical practices have changed and people stay in hospital for shorter times. The community's expectations of safety and good clinical outcomes have increased, and smaller hospitals — with few cases of each type — no longer offer an obstetric service or undertake surgery requiring a general anaesthetic. These smaller hospitals are concentrating their resources on medical treatment, follow-up care, aged-care services and community-based services thus

providing primary health care and promoting the health of the their community (National Rural Health Policy Forum and National Rural Health Alliance, 1999).

2.5 The district management model

The role of the DON/HSM, the focus of this research, has emerged in these smaller hospitals following a restructuring of rural health services in Western Australia and the adoption of a district model of management in 1994. Prior to the restructuring, the state was divided into administrative regions, and a Regional Director managed the hospitals (or provider units). The Regional Director, in turn, answered to the Commissioner for Health and, hence, the State Minister for Health. Much of the operational management of these provider units — including strategic planning, financial management and human resource management — was carried out by the office of the Regional Director.

At the provider-unit level, the hospitals were typically managed by a Director of Nursing (responsible for the delivery of clinical services), an administrator (responsible for the financial management and the management of the hotel services). Both positions were answerable to the Regional Director. Some hospitals (known as board hospitals), had hospital boards whose role varied but was mainly advisory. The boards were comprised of volunteer community representatives, and the history of the board could usually be traced back to the hospital's origins as an outcome of community endeavour. Not all hospitals had boards. Hospitals built by the HDWA typically did not have boards appointed. Other and other boards had been disbanded and responsibilities handed to the HDWA. Such hospitals were known as department hospitals'.

In 1994 the then Minister for Health began the implementation of a district management model for rural health services. Under this restructuring, the regional directorates began to relinquish their line-management role over rural health services (Health Department of Western Australia, 1994). Smaller health districts were created and a general manager appointed to oversee the district.

A district was an aggregate of health care units, health services and localities. There were no guidelines for a standard district structure, with all rural regions identifying district boundaries according to their particular needs. This led to the creation of 17 health services across the state, with considerable differences in terms of geographical size, population and health problems. The number of hospitals within each health service ranged from two to six. (See Figure 2.1.)

Each health service (the name by which districts are referred) was managed by a general manager who was accountable to the Commissioner for Health and supported by a district office. Those who filled this new position of General Manager, in the main, had a background in general administration. At the time of writing, there was only one general manager who has a clinical background, and is, incidentally, the only female. The role of the General Manager was to control and integrate all health programs within the district and to ensure that the district operated under statutory requirements. Being a new position, there was wide variation in the way in which the General Managers interpreted their responsibilities. The relationship between the General Manager and the local health services varied considerably across the Health Services in the State.

Another significant change in the implementation of the district management model was the changed role of the hospital boards. Under the reforms, rural hospital boards of management became pivotal in maintaining direct community responsibility and input into rural health services. The boards became a statutory authority that governed the operation of the provider unit. With this change, the Health Department of Western Australia relinquished its central control over rural hospitals. Where boards did not exist, they were established.

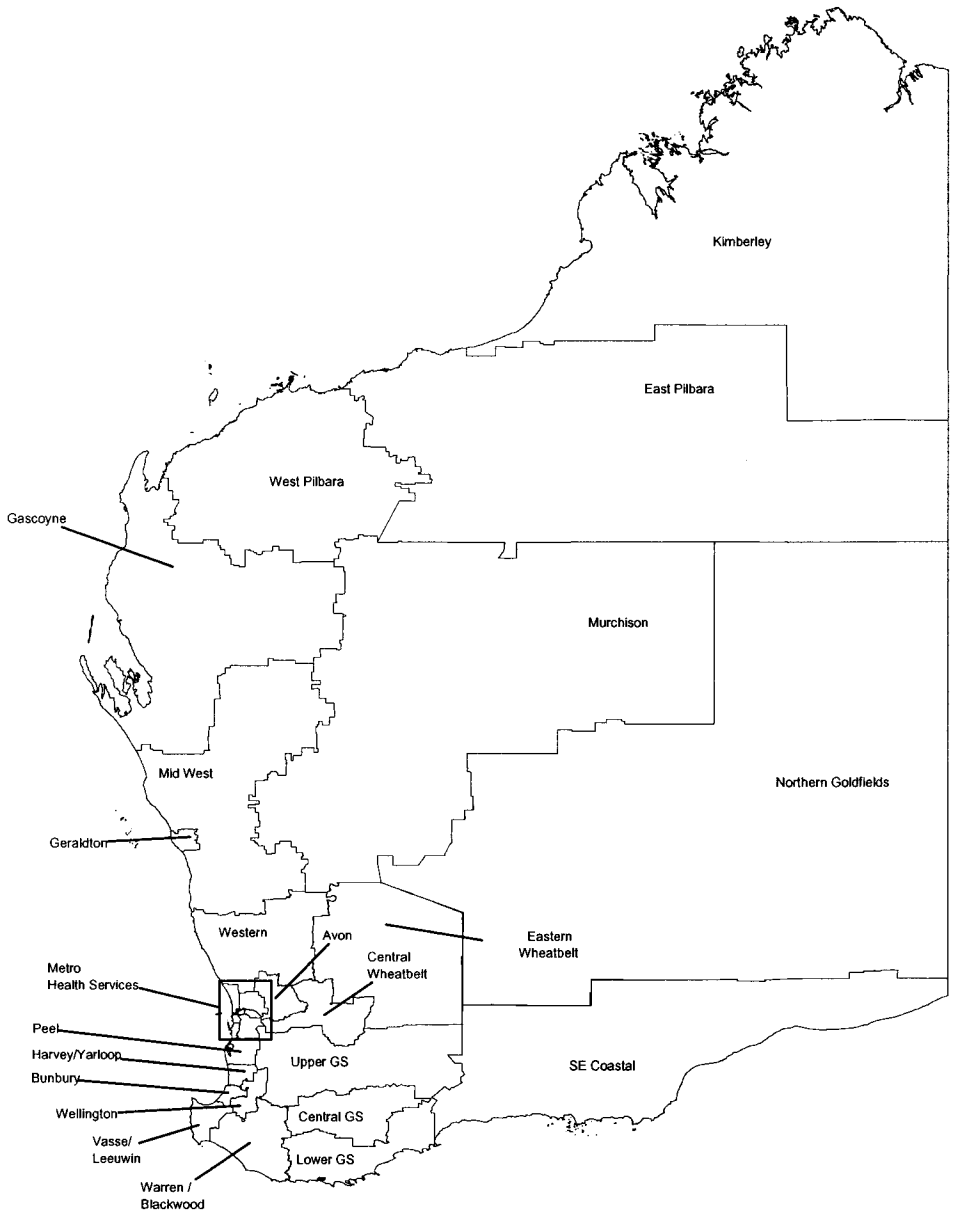

Figure 2.1: Health service areas of Western Australia

The role of hospital boards was identified to include:

1. establishing the strategic direction of the health service;
2. setting policy;
3. delegating authority and establishing organisational structure;
4. overseeing finance and safeguarding assets;

5. evaluating and monitoring performance standards;
6. ensuring that the board itself is effective;
7. promoting the health service and lobbying on its behalf in the community;
8. ensuring proper working relationships with other agencies, organisations and the community; and
9. ensuring that staff is employed to carry out the work of the organisation and that the health service environment is effective.

(Health Department of Western Australia, 1999)

There was considerable variation in the manner in which the boards carried out their responsibilities. New boards had to learn their role, and older boards had to adopt new responsibilities. It also became apparent that dealing with the large number of statutory authorities (all of which were required to generate annual reports and performance indicators for tabling in parliament) was rather unwieldy. The HDWA made recommendation in 1997 that hospital boards be amalgamated into district boards. Representatives from each hospital board in the health service would become a district board and the statutory authority.

Hospital boards would remain but only in an advisory capacity. This led to various changes of name (such as the Hospital Management Committee) to reflect this change of responsibility. While this recommendation has been adopted in a number of health services, it has created conflict and unrest in others, with hospital boards reluctant to give up what they see as control over their community's health service. At the time of this research, this issue is unresolved. Some health services have district boards, and others have individual hospital boards. One health service has a district board but has one hospital that has refused to come under this umbrella and is maintaining its hospital board. These anomalies contribute to the variation in management structure and style in each of the health services.

As identified in role 3 earlier ("delegating authority and establishing organisational structure"), it became the role of the board to establish the organisational structure for the health service, and it was this stage that saw the creation of the DON/HSM role. This role

was a new initiative and resulted from combining of the Director of Nursing role with that of the administrator. Because the role required the incumbent to be a registered nurse, the Directors of Nursing were required to take on the role. There was no increase in remuneration, and the incumbents were to continue to be paid according the Australian Nursing Federation Award. There had been some precedence for the role, there having been a trial in one region in 1989, but it was only after the introduction of the district management model in 1994 that the role of DON/HSM was generally adopted.

There appears to be several issues that precipitated the change as the adoption of the role was not a requirement of the plan for the introduction of the district management model. A number of hospital administrators had become General Managers or moved to the District office. There had also been a number of hospital administrators who had retired. This created a shortage of experienced hospital administrators. Several Directors of Nursing at the time were actively promoting the combined role, seeing it as a way of increasing the influence of nursing in the state health system. The HDWA also saw it as a way of preparing nurses for general management roles and, possibly, correcting the gender imbalance in the ranks of the general management. Probably one of the largest considerations was that the hospital boards saw that with the removal of one wage, the move was a considerable cost saving.

The decision to move to the DON/HSM role lay, however, with the hospital board and, in the absence of the hospital board (some were yet to be established), the General Manager. Over the next few years following the implementation of district management, most — although not all — smaller hospitals in the southern half of Western Australia adopted the DON/HSM role.

In general, the role of the DON/HSM was to:

- Direct clinical services.
- Manage the delivery and integration of health programs in their locality.
- Be responsible for meeting local health care gains as contracted.

- Establish and maintain links with stakeholders as required.
- Manage all resources of the health service.
- Liaise with other related health service providers and non-government agencies.
- Participate and assist in all needs analyses.
- Undertake a clinical caseload as required.
- Lead operational and strategic planning for the health service.

(Central Health Authority, 1994)

Although there was some variation between health services, a typical structure is represented in Figure 2.2.

2.6 Changes in the role of the DON/HSM

Since the implementation of the DON/HSM role in 1994, there have been a number of changes in the administrative requirements of the HDWA, reflecting the policy of decentralisation. Many of these changes have impacted the function of health service management and, hence, the role of the DON/HSM. These changes to the health system included new requirements for the construction of service agreements with associated negotiation, output specification and monitoring, which necessitated the resetting of priorities and varying investments between programs (health condition output groups) and/or between interventions (key outputs). The health investment strategies articulated the decisions reached on the reordered priorities. It was a requirement that the health investment strategies be translated into price-, volume- and service-specific agreements with providers in any financial year.

In association with the budgetary reforms, there has also been a change to accrual accounting methods. Traditionally the rural sector had a cash-based accounting system that was centrally managed, and data entry was the only requirement from the sites. With decentralisation, the need for rural sites to have timely and accurate accrual financial information to fulfil management reporting and legislative requirements became apparent.

Other budget reforms have included the application of costing benchmarks that were intended to encompass all contracted activities and services. Activity targets and the allocation of funds are based on the development of a Memorandum of Understanding (MOU) between the health services (as providers) and the HDWA (as funders). These changes have required some sophisticated management skills on the part of the DON/HSM. One of the biggest changes impacting on the DON/HSM role has been the development of the MultiPurpose Service (MPS) program.

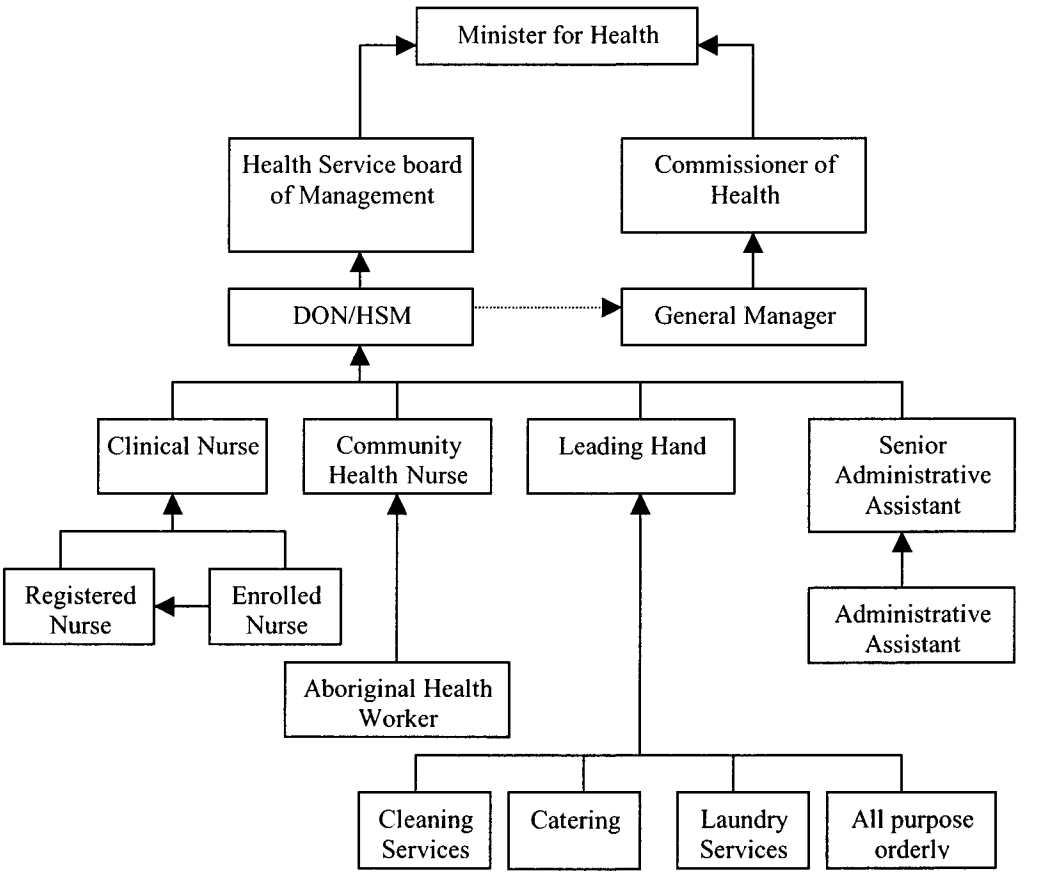

Figure 2.2: The organisational structure of rural health services

2.7 MultiPurpose Service Program

The MultiPurpose Service (MPS) program involved the pooling of both state and Commonwealth funds to enable the integration and development of hospitals, community health services, hostels, nursing homes, Home and Community Care (HACC), medical and pharmaceutical benefits, ambulance and allied health services.

The program was implemented to address problems unique to rural health service providers, which included:

- It was becoming economically nonviable for rural hospitals to deliver discrete services to small populations.
- There were difficulties recruiting staff including general practitioners.
- There was an increasing need for appropriate, local-community aged-care facilities and services, yet there was a recognised difficulty for such services to survive on their own.
- There was a frequent duplication of limited resources and infrastructure.

These difficulties were often characterised in communities with situations such as:

- a local hospital with eight beds, requiring full staffing capacity yet servicing few in-patients;
- an aged-care hostel with ten beds, but servicing only four residents and experiencing enormous difficulty in remaining solvent as well as meeting Commonwealth Standards;
- a local Home and Community Care (HACC) service that, in many cases, relies in part on volunteers to coordinate services ranging from transport to meals on wheels and personal care; and
- separate program barriers restricting the above services ability to work effectively together by sharing resources and effort.

(Rural Health Policy Unit, 1995)

Developing an MPS requires approval by both Commonwealth and State Ministers. The process involves the following steps:

Step 1: Expressions of interest in developing an MPS are requested by the MPS State Steering Committee. Submissions from rural communities are considered, and State and Commonwealth support is provided to assist a community consultative process.

Step 2: Comprehensive community and service-provider consultation is undertaken.

Step 3: Written endorsement of the MPS proposal is sought from all key stakeholders, with full disclosure of any potential impediments.

Step 4: A health-and-aged-care needs assessment is undertaken, and this establishes the foundation for the development and direction of future health and aged-care services.

Step 5: A plan is developed to demonstrate how services could be delivered to better meet health-and-aged-care needs in the community. All service providers must agree to this plan prior to any further development of the MPS.

Step 6: A transmission of business process, including a human resource plan, is undertaken.

Step 7: Appropriate levels of funding are established. These funds may incorporate hospital, HACC, community health and residential community-based aged-care funds.

Step 8: A three-year agreement is signed between the MPS and the State and Federal Governments.

After the first pilot program, there are now 15 MPS sites in rural Western Australia, with a number of other sites in the process of development (Health Department of Western Australia, Annual Report 1998/1999).

There are some enormous challenges in the process of implementing an MPS. Considerable time and effort is required, and this is particularly the case for community representatives, many of whom are volunteers. The development of the needs analysis and the plan requires substantial effort. In most cases, the role of planning and implementing the MPS has fallen

on the DON/HSM. Although there was funding available to employ assistance in the planning process for pilot programs, these funds are no longer available.

Following the implementation of the MPS, the responsibilities of the DON/HSM increase considerably. The MPS program is designed to provide one management structure for all health and aged-care services with one source of funds (pooled funding) and a single accountability process for all the health and aged-care services offered in a community. The DON/HSM, therefore, becomes the manager and the clinical leader across the whole program in addition to retaining his or her previously held responsibilities for management of the health service.

This chapter has described the practice environment of the DON/HSM. It has reviewed the health care issues characteristic of rural areas and relevant to the clinical practice of the DON/HSM. It has described the implementation of the district management model in rural Western Australia and the associated creation of the DON/HSM role. Significant changes in the management component of the role, precipitated by the establishment of decentralised management and the move towards MPS programs, were identified.

The next chapter builds a theoretical foundation upon which the research is based by reviewing the relevant literature.

Chapter 3: Literature review

3.1 Introduction

This chapter reviews the literature relevant to the area of inquiry. The review considers a number of areas of concern. The first section reports on the literature relating to the role of the clinician manager. The second considers work-role transitions as an approach to understanding the role and then attention is turned to role theory. Symbolic interactionism as an approach to understanding roles is considered, and then sensemaking as an application of symbolic interactionism in the organisational context is explored.

Section 1

3.2 Background

Recent times have seen considerable changes in health care (Issel and Anderson, 1996). The World Health Organisation (1994) identified a number of factors that are driving change in all parts of the world. These factors include cost constraints, an ageing population, the impact of technology, increased consumer knowledge (with a concomitant desire for better health outcomes) and changes in the health task from acute to chronic conditions. In response, the health services industry has begun to concentrate on ways to improve operations and achieve overall cost effectiveness (Thorngren and Tinstman, 1990). It has developed and implemented structural changes to address issues of cost containment, utilisation and resource allocation (Leatt et al., 1991). One approach has been to decentralise resource-allocation-and-utilisation decisions to the program or unit level. The belief is that by altering organisational structures in this way, clinicians who were previously responsible only for patient care decisions will now participate in controlling costs (Meslin et al., 1997). A new type of clinician, the clinician manager has emerged to take on this task.

3.3 Health service professionals and management

Health service organisations are typically characterised by a complex division of labour and differentiation whereby different tasks and organisational goals are traditionally assigned to different occupational groups. Historically, hospitals were structured around clinical hierarchies that were internally stratified. There was a division between the rank-and-file practitioner and the supervisory professional (Thorne, 1997). These supervisory professionals were responsible for the delivery of clinical services but did not control budgets. General administrators were accountable for the financial performance of the organisation but normally played a supporting — rather than controlling — role. The general administrator's role was difficult, as they could do little to influence professional practice (Southon, 1996) and were faced with the responsibility for budget control when some 70% of the resources were consumed by a group who vigorously defended their right to independent practice (Shortell and Kaluzny, 1997). This situation was supported by the notion of clinical autonomy.

3.3.1 Clinical autonomy

The principle of clinical autonomy (the term "clinical freedom" is used synonymously) has been pervasive in the organisation and management of health services. Harrison (1989), following a review of the literature and a series of interviews with medical practitioners, reported that clinical freedom is an elastic concept, and its practical meanings vary with time and context. Generally, clinical autonomy is the belief that clinical practice should be free from managerial or organisational constraints upon decisions about how to treat patients. Harrison suggested that the concept of clinical autonomy had its origins in nineteenth-century medicine, upon which modern medical law and ethics are still largely based. At that time the only actors in clinical practice were the medical practitioner and the patient. The medical practitioner provided advice and/or treatment in return for "informed consent" to any such treatment, together with a fee. The only limits to treatment were the competence of the medical practitioner and the patient's consent and financial resources. As Duckett (1994, p.117) wrote "Each doctor had, by virtue of his training, a God-given right to order what care, in what quantities at what time, regardless of effect". Medical practitioners have defended the right to clinical autonomy with vigour. Associated with

clinical autonomy is the notion of peer review: the only one with the right to challenge the practice of a medical practitioner is another medical practitioner. The ability of a general administrator to challenge medical practitioners over the use of resources and the services to which they give priority is extremely limited (Harrison, 1999).

Clinical autonomy raises professional, ethical and economic issues. The inclusion of a third party in the patient-care relationship (owners, health insurance companies and — in the case of the public health service — the state), all with a finite budget, has led to some challenges to the absolute right to clinical autonomy. The medical profession has resisted any effort at change. Despite attempts from the 1960s onwards to bring the implications of medical decisions into the open, the principle of clinical autonomy has continued to give medical practitioners a position substantially free from the managerial restraints that would normally be expected to be applied to most organisations (Dent, 1993).

Although the right to autonomy of practice is a particular characteristic of medical practice, it is also a feature of the practice of other health care professionals such as nurses and allied heath practitioners. Professionals claim the right to autonomy as they consider their educational preparation provides them with a unique body of knowledge (Macdonald, 1995). Flynn (1999) cautioned that considering professional autonomy and bureaucratic managerial control as dichotomous is not adequate to describe the complex and dynamic relations that typify professionalised occupations. Professionals constantly seek markets for their skills and endeavour to maximise their independence, but at the same time, employers — through managers — will continue to attempt to regulate and control expert labour. Professional autonomy is thus contested, variable and contingent upon many factors, often leading to a struggle for power between health care professionals and health service management. Medical or management priority decisions were often made in isolation and with inadequate information about costs and outcomes. It was easy for health care professionals and managers to use each other as scapegoats for unpleasant choices that restrict patient care (Fitzgerald and Sturt, 1992).

3.3.2 Management–clinician conflict

The theme that health service professional and general managers stand in a necessarily antagonistic relationship has been recurrent in the literature (Burgoyne and Lorbiecki, 1993; Dawson, 1994; McErlain-Burns and Thompson, 1999; Southon, 1996; Stoeckle and Reiser, 1992). The reasons for this conflict are many and are related to a history of adverse relationships characterised by a lack of trust, an inability to identify common ground and a failure to agree on a collective vision of the future (Meighan, 1994).

Fitzgerald and Sturt (1992) reported that clinicians not involved in formal management tend to assume that management is a technical matter, devoid of uncertainty, moral or emotional issues. Clinicians are distrustful of management as it does not have the scientific base that their professional training leads them to expect in technical areas. Dawson (1994) suggested that professionals have two different perspectives on the meaning of management. One view sees the manager as a subservient facilitator — somebody to take care of the mundane administrative activities hence facilitating professional practice. The other view sees management as a constraint. In the latter view, the management role is likely to have more impact as managers could effectively curtail and limit professional activity. As a consequence, the professional considers managers to be an imposed external and often unhelpful constraint. Managers are seen as attempting to shape the health care professions in order to meet the changing health care environment. As a response, health care professionals are developing strategies to maintain their position and to adapt to change on their own terms (Schneller, 1996). Conflict and antagonism often results from competition for scare resources and is symptomatic of attempts to reconcile two distinct and conflicting modes of working —professional and bureaucratic (Raelin, 1985).

The antecedents of conflict can be illustrated by the cultural difference between health service managers and health professionals. These two key groups are, as suggested by Southon (1996, p. 15) "marching to very different drums". The contrasts between professional and managerial perspectives are summarised in Table 3.1.

Table 3.1: Contrasts between professional and managerial perspectives (Southon, 1996, p.19)

	Professional	Management
Principal orientation	The task at hand, the client	The organisation, resource allocation
Source of power	Expertise, reputation	Hierarchical authority, conferred responsibility
Important organisations	Professional networks and associations	Institutions
Authority	Scientific evidence and accepted practice	Policy and accountability

The differences between the medical or professional culture and the managerial culture have dominated discussion of professional–managerial conflict. Burgoyne and Lorbiecki (1993) suggested that medical culture contained at least three elements that can be related to mental habits and orientations: (1) attitudes and values of professional autonomy; (2) the use of specialist language; and (3) specific work practices. This may result in what Fitzgerald (1992) described as mutual stereotyping. For example, in the same way that medical clinicians have a specialist language that is difficult or impossible to comprehend for non-members, managers also have their own equally as incomprehensible jargon. The use of private and excluding language allows each group to locate blame, problems and responsibilities with each other (Burgoyne and Lorbiecki, 1993). This stereotyping is a barrier that can only be overcome by both sides taking a considerable risk in self-disclosure (Fitzgerald and Sturt, 1992).

Menzies (1960) suggested that much of health service structure and culture can be interpreted in terms of defence against anxiety. Anxiety is created by the nature of health services and associated with dealing with illness and disease. In order to allay feelings of anxiety, health service organisations have developed a culture that allows everyone to locate worry and responsibility elsewhere. From this point of view, the inexplicable and seemingly irrational clash between clinical and managerial culture may appear rational. This may also account for the prestige of clinicians, the resilience of the cultures and the norms of clinical autonomy. Burgoyne and Lorbiecki (1993) suggested that this approach

clarifies two problems that are likely to occur with the change of managerial practices in health care organisations. First, resistance to the transparency required of many managerial processes is likely to come from those protected from anxiety by the tradition of ambiguous situations and misunderstandings. Second, the extent to which the managerial processes relocate the point to which the anxiety is deferred will relate to the magnitude of the defensive strategies mobilised by the interested groups.

3.3.3 Clinicians as managers

One approach taken in an attempt to resolve the conflict inherent in differing value systems has been the involvement of clinical staff in formal management structures. As Hoggett (1996, p. 243) states: "rather than try to control professionals by managers, you convert professionals into managers (by giving them budgets and setting them adrift as quasi-autonomous business units)". This is done in hospitals by restructuring.

Health services have traditionally entailed a complex relationship between professional and management activities. All health care professionals (including medical practitioners, nurses, therapists and social workers) have always been engaged in managing their work and the care of their patients in the professional domain. Professional practice, however, was often only loosely coupled to the mainstream managerial work of the wider organisation, and clinical practitioners traditionally had no direct accountability for the management of resources or for the work of others beyond their professional area of practice (Harrison and Pollitt, 1994; Thorne, 1997). Health care professionals were responsible for patient care and general managers were seen to be in a support role, managing and accountable for the resources that provided the environment for professional practice. Restructuring of hospital services and the creation of clinical managers were designed to increase accountability for resource allocation (Southon, 1996).

In Australia, the restructuring of hospitals was signalled in 1991 when the National Health Strategy recommended:

> Altered internal organisational structures for hospitals for the clinical work force along divisional lines ... this strategy would facilitate improved knowledge, responsibility and accountability amongst clinicians; and provide incentives for more cost-effective management.
>
> (1991, p149)

This approach had precedents in the United States and in Britain. (See Boyce, 1993, for an overview.) The key element of the structure was a clinical team that reported to the director of the clinical service. Program directors were clinicians and, in most cases, medical practitioners who were given responsibility for their identified budgets across hospital and community settings and expected to plan, control, evaluate and service within their directorate (L. Lee, 1995). Many variations of the clinical directorate model have developed, influenced by the size of the hospital, types of services offered and the skill mix of the staff.

In addition to clinical directorates, Australian hospitals (also in keeping with overseas trends) have moved from hierarchical models of management to decentralised organisational structures where the alignment of responsibility is at the clinical level or point of service delivery (Eastman and Fulop, 1997). The principal reasons for this have been shrinking budgets, rising costs and the failure of central administrations to manage these crises through successful cost-containment measures that would have allowed them to maintain the quality and quantity of clinical services (Chantler, 1989). This move has been underpinned by the notion that cost-containment decisions are best made at the service-delivery level. Concomitant with decentralised organisational structures and the reduction in middle management has been the appointment of clinician managers at all levels of management.

The notion of a clinician manager is not new. Clinical practice entails many activities of a managerial kind such as supervising the work of non-professionals or professionals of lesser expertise. The new clinician manager role that emerged encompassed accountability for human resource management, cost control, quality monitoring and business planning (Fitzgerald and Sturt, 1992). Fitzgerald and Sturt emphasised that the emerging clinician manager role was a new role and not a part-time manager performing tasks as any other

manager might do. Uniquely, a clinician manager combines direct and current clinical expertise with management expertise to take decisions about the range and quality of services offered. Because of the often conflicting demands of clinical practice and management responsibility, it is difficult to apply management theories to the everyday experiences or work of clinician managers (Eastman and Fulop, 1997).

When considering the new clinician manager roles, Causer and Exworthy (1999) cautioned that it is not appropriate to consider the professional and management roles as a dichotomy. Rather, these authors suggested a more complex typology that reflects the varying ways in which professional and management activities may be related to one another. They argued that different individuals might interpret and enact their roles in different ways. Three broad roles were identified each of which may be differentiated into two types.

First, there was the role of the practicing clinical professional whose primary function was clinical practice. Practicing clinicians may be divided into those whose work involved no supervisory or resource allocation activities and those for whom the exercise of such responsibilities was an integral part of their activities even though they were not formally designated as managers.

Second, there were those clinicians whose primary responsibility was the day-to-day management of the work of other professionals and the resources utilised in that work. This group may be internally differentiated according to whether or not the clinician manager continues, alongside their managerial activity, to maintain some direct engagement in professional practice. This category of clinician manager may therefore be divided into two groups — the practicing clinician manager and the non-practicing clinician manager.

Finally, there are those who have an overall managerial responsibility for the activities of professional employees but who are not themselves concerned with the direct delivery of day-to-day practice. This group may be considered to be general managers; however, they may or may not have a background in clinical practice, again creating two subgroups.

Of the six groups identified in the typology, five are characterised by their past or present engagement in clinical practice. Of issue are the motivation of clinical professionals who assume managerial roles, how they acquire managerial skills, and how they interpret the new role in the face of the competing demands of clinical and managerial practice.

There is limited research evidence on clinical management roles and their operations. This is despite the trend towards establishing clinical directorates and the dramatic acceleration in the appointment of clinician managers as clinical directors (Fitzgerald and Sturt, 1992). Most of the literature concerning the clinician manager role discusses medical practitioners or nurses.

Medical practitioners as clinician managers

The research literature relating to medical practitioners as clinical managers is limited. The majority of the literature emerges from the United Kingdom where changes in the National Health Service (NHS) over the last twenty years have increasingly involved medical practitioners in the allocation of organisational resources. Concomitantly, there has been a rapid adoption of the clinical directorate model as the favoured mode of organisation in acute units, leading clinicians to assume general manager roles (Fitzgerald and Sturt, 1992). Nevertheless, most articles are "reflections" (e.g. Mark, 1995) and "commentaries" (e.g. Dawson, 1994) rather than reports of research results. The research articles were few.

Willcocks (1994) reported data on the role of the clinical director collected from a NHS Trust case study. Role theory was used to focus on role performance, role expectations and the relationships between roles. Willcocks found that the clinical director role could be viewed in relation to whether occupants were able to meet expectations of the role set. Role perceptions depended on individual, interpersonal and organisational factors but influenced the clinical director's ability to perceive the role and enact it. Effectiveness in the role was seen as the extent to which the occupant was able to influence, adapt, modify or change role expectations, reconcile conflicting expectations or live with multiple expectations.

Fitzgerald (1994) reported the findings of a study of a cohort of 31 clinicians as they assumed management responsibilities and followed their progress as they undertook

training at business schools. Fitzgerald found that the clinical director's role appeared to have been modelled on an average general management role, instead of being conceived as a unique new role. It is apparent that further thought was needed to define a part-time clinical manager's role. The clinician managers constantly assessed time spent on management activity against the criteria of what would be achieved by using that time for clinical practice. Fitzgerald suggested that clinicians assumed roles that are ill defined and further suggested that such roles might not be the most effective use of professional expertise. Should this continue, the concern was that health service management would not improve (and probably deteriorate) and the rift between managers and clinicians would increase.

Using case-study methodology, Thorne (1997) explored medical practitioner's experience of the role of clinical director in a large NHS teaching Trust. The research demonstrated that being a clinical director threatened professional identity, collegiality and autonomy of both the individual and the professional group the directorate represented. The stress that emanated from the structural tension inherent in the role was displaced into personal and professional stress. Clinical directors embodied the tensions and conflicts of different managerial and professional cultures and attempted to reconcile the demands of the organisation with the disparate views of often difficult professional colleagues. The ambiguous nature of the role and the lack of preparation provided to undertake it induced part of the stress of becoming a clinical director. The role was perceived by the practitioners as that of a part-time general manager. This observation has been made by others (Fitzgerald and Sturt, 1992; Mark, 1995; Mumford, 1989; Willcocks, 1994). Thorne (1997) pointed out, however, that the role was interpreted and executed differently in most cases — influenced by the individual, the professional group and the demands of the organisation. This supported the finding of Willcocks (1994). The clinical manager role was best understood as a hybrid of the professional role but lacked the history or tradition of clinical practice.

Burgoyne and Lorbiecki (1993) reported findings following in-depth interviews with 60 clinicians involved in formal management activities in the NHS. Generally it was found

that the transition required additional skills and an orientation that required forms of learning with which the clinicians were unfamiliar.

Of more concern was the finding that the clinician managers found the maintenance of their credibility and esteem to themselves, their professional colleagues and to the public was seriously threatened. It was apparent that, in contrast to the majority of professional groups where career advancements beyond a certain stage was dependent upon a move away from clinical practice, in medicine high status and rewards have been associated with the continuation of practice. Thus medical practitioners, even at very senior levels of management, associated their credibility with their clinical practice. This supported the view expressed by Causer and Exworthy (1999).

Burgoyne and Lorbiecki (1993) suggested that clinicians were becoming involved in management and making the personal and social adjustments necessary for this but in a way that left medical culture, and their allegiance to it, largely intact. This reflected a concern that Turner (1990) described as deprofessionalisation — the loss to a professional of the unique qualities a professional role offers. These professional qualities include, particularly, the monopoly over knowledge, public belief in a service ethos and expectations of work autonomy and authority over the client. Turner suggested that deprofessionalisation came from role changes in the professional's role set, such as a move into management, and associated this with reforms in the health care industry.

The future of the role in the longer term will depend on the conception of a new role, that of the clinician manager, rather than maintaining the role as one of a part-time clinician and part-time general manager. If the clinician manager is to be a long-term reality, rather than a politically expedient experiment, a much clearer understanding of the role and effective individual adaptation to the role is essential.

Nurses as clinician managers

Nursing offers a different perspective. There has always been an implicit recognition that the nurses' role contained a considerable management component (Cohler and Kaluzny,

1988). At one level, the work of registered nurses has long involved functions of a managerial kind, with nurses having significant responsibilities for the direction and monitoring of the work of junior and unqualified nursing staff (Mackay, 1993). There are indications, however, that there are significant changes to the nurse managers role in various parts of the world.

To illustrate the direction of these changes, a distinction is made in the literature between the terms "nurse manager" and "nurse in general management". In the first, the nurse functions as a nurse; in the other, the nurse moves beyond nursing into general health management. This is described further in the following table.

Table 3.2: Nurse management functions (International Council of Nurses, 1990, p. 65)

Nurse Manager	Has management role and functions, primarily related to nurses, nursing or nursing services. The position is required to be filled by a nurse on the basis that nursing knowledge and judgement are pre-requisites to the management functions of the position. The position is seen as essential to contribute to the goals of the organisation. The nurse manager has accountability for the functions related to nursing and sometimes to nurses or to a combination.
Nurse in General Management	Has management roles and functions primarily related to the broader field of health care management where the position is not required to be filled by a nurse. The manager is therefore not functioning as a nurse but can have much to contribute to the position from their nursing background.

The term "nurse manager" itself was clarified to expand on the difference between the management of nurses and the management of the nursing function. (See Table 3.3.) The feasibility of dividing the two roles was debated in the literature. It appeared that the management of nurses attracts greater attention as a major component of the hospital budget is spent on the employment of nurses (M. Flynn, 1998).

Table 3.3: The scope of nurse managers (International Council of Nurses, 1990, p. 68)

Management of nurses	Management roles and functions related to nursing staff e.g. recruitment, orientation, allocation, activities, leave etc.
Management of nursing	Management roles and functions related to the development of professional nursing, its practice and its standards, appropriate to health needs (sometimes referred to the management of the nursing function).
Management of nursing services	Management roles and functions related to nurses, nursing (the nursing function) or a combination of both, whatever is most appropriate to the particular health structure and the country concerned.

An extensive number of commentary articles have been published in the nursing literature describing the nurse manager's roles. Only a small number of research articles have been reported. These have related to both senior management and first-line management. The articles described the competencies expected of a first-line nursing manager (Duffield, 1989); the professional gatekeeper role of the ward sister (Lewis, 1990); competency groups related to nurse manager success (Dubnicki and Sloan, 1991); the developing trends in nurse management roles and the evolution of the corporate-director management role (Hennesy, Rowland and Buckton, 1993); the knowledge and skills required for first-line nurse management (Duffield et al., 1993); the key responsibilities of the chief nurse executive role (Jaco, Proce and Davidson, 1994); a model of nursing managerial work (Mintzberg, 1994); the emerging role of the nurse manager and educational preparation (Mark, 1994) and an interview guide to identify effective nurse managers (Everson-Bates and Fosbinder, 1994).

Because of their diverse nature, the different research methodologies and the variety of reporting mechanisms, comparison of these studies is problematic. It appears that the various researchers have made differing interpretations of what is understood by competencies. Some reported role functions as competencies and others the skills and abilities required for role performance. All the studies reported a blending of the

managerial and nursing functions as central to the nurse manager's role. The emphasis was on management functions. Clinical functions received little discussion, and possible conflict between the two areas of concern was not considered.

In summary, the function of the nurse manager was generally considered to fall into four broad areas: economic management, staffing, facilitating communication, and professional and personal development. Qualities of self-confidence, high achievement orientation, analytical thinking and persuasion skills were commonly considered to be important. The literature on nursing management focused on the management of nurses for nurses (M. Flynn, 1998).

Recent research (Knox, 1995; Persson and Thylefors, 1999; Willmot, 1998) has explored changes in the role of the charge nurse. In a new role, the nurse manager has the autonomy to manage a ward and its resources, with an emphasis on the integration of clinical knowledge and effective management decision making (Oroviogiocoechea, 1996). Willmot (1998), following in-depth interviews with nurses in the new role, found that although most of the nurses were in favour of the development of the new role, many felt that the change process had been managed ineffectively. There had been insufficient consultation during the change process, preparation and support were perceived as inadequate and the roles of those involved were often unclear. Role conflict and role ambiguity were frequent complaints. Persson and Thylefors (1999), exploring a similar role change in Sweden, found that nurses saw the role as a move away from nursing into a management role with a new professional identity characterised by the acquisition of management skills and the loss of nursing skills. A striking finding of the study was the unwillingness of the nurses to return to nursing. The expanded management role was seen as a "career with no return".

The literature appeared not to consider the case of a nurse in a clinician manager role where the job entails responsibilities for general management (i.e. accountability for a management role beyond that of the nursing service) yet retains a clinical role. While the maintenance of clinical involvement was seen as a priority by the medical profession (see the previous discussion), the situation appeared to be different in nursing. For nurses, to

move into management is seen as moving away from a clinical role, and this loss of the clinical role is viewed without regret. The implications for nurses in a clinician manager role are far from clear.

3.4 Transitions from clinician to manager

The challenges, practical and personal, for health professionals who make the career change into a managerial role frequently make the adjustment difficult (Fitzgerald, 1994; Lawson, Rotem and Bates, 1996; Mark, 1995; Thorne, 1997; Tobin, 1993; Willcocks, 1994). Prideaux (1993) in a qualitative study of clinician managers, identified the difference between the operating environment of the clinician and the manager under seven headings. These are shown in the following table.

Table 3.4: Clinicians vs managers (Prideaux, 1993, p. 7)

	Clinician	Manager
Tasks	Clear, well understood	Unpredictable and ambiguous
Role	Authority clear	High level of responsibility but authority not clear
Relationships	Small number of professional colleagues	Large network across the organisation
Orientation	Patient focus	Organisational issues
Thinking and decision processes	Systematic and rational	Ad hoc, incremental and intuitive
Skills	Clinical competence	Wide range, including political skills, managing people, financial management

The main area of difficulty for the clinician manager was to find the right balance between the requirements of the manager (to place the welfare of the organisation as the highest priority) and the conditioning of clinicians to place the patient as the highest priority (Clifford, 1981; Quivey, 1985). How to balance these competing demands was far from clear. Little guidance was offered in the literature. Articles that described the health service

management job — both at a general and functional level (Duncan, Ginter and Capper, 1994) and at an executive level (Kleiner, 1984) from the perspective of the physician manager (Betson and Pedroja, 1989) — across multidisciplinary groups (Kaluzny, 1985) and in a decentralised system (Malcolm, 1990; 1994) made little or no reference to the clinical component of the job or the process of adaptation to the job. It was suggested by Mark (1995) that transition skills were critical for health care professionals moving between the professional domain, management and varying points in between.

It is readily apparent that further understanding of this relatively new but important clinician manager role is needed. Most contemporary management theories have not provided an adequate conceptual or practical approach for accommodating the clinical element of the role (Eastman and Fulop, 1997). The role of the clinician manager has unique characteristics, and it is inappropriate to consider the role as a type of part-time general manager. There are issues related to the conflict in value systems between that of a clinician and that of the manager that the growing body of evidence suggests places inordinate pressure on those in the role of clinician manager. The effects of this pressure on the individual and their performance in the role are poorly understood. It is essential for the ongoing viability of the health care industry that this role, if it is to continue, is operationalised appropriately.

Clinician managers were drawn from the ranks of medical practitioners, nurses and allied health professionals (Eastman and Fulop, 1997). It is likely that each professional group may have a different response the change of role. The need to study the role in a particular context is apparent, and the need for more research into all aspects of the work role is paramount. Of concern is how the professional incumbents of management roles understand the role and adapt to it.

Despite the paucity of research in the area, a number of writers have proposed conceptual approaches that could frame such an inquiry; for example, transition skills (Mark, 1995; Prideaux, 1993) and, more commonly, role theory (Burgoyne and Lorbiecki, 1993; Fitzgerald, 1994; Flynn, 1998; Stewart, 1989; Willcocks, 1994).

The literature relating to work-role transitions was explored to assess its contribution to the understanding of the adaptation to the role of the clinician manager.

3.5 Work Role Transitions

Mark (1995) identified the need for health care professionals moving between the management and professional domains to develop transition skills. Work-role transitions can have profound consequences for the future development of individuals and their organisations (Nicholson, 1984). The process of inventing and developing a new role has high costs in time, worry, conflict and temporary inefficiency (Krackhardt, 1995). Some attention has been paid to the issue of work-role transitions in the literature.

Nicholson (1984) defined work-role transitions as any change in employment status or any major changes in job content. Transitions therefore, could relate not only to the consequences of mobility but also to the outcomes of job redesign and organisational change. Nicholson developed a model of work-role transitions that proposed a conceptual framework that linked personal and situational causes with individual and organisational outcomes. The intention of the model was to show how transitions, according to their characteristics, could sustain continuity or engender evolutionary change in personal and social systems. The model proposed that work-role transitions involved two independent adjustment processes: personal development and role development. Personal development involved reactive change in the individual, which ranged from minor alterations to daily routines and habits through to major developments in relationships and self-image. Role development involved moulding the new role to suit the requirements of the job holder, which ranged from minor initiatives to major changes that affected the goals of the organisation.

Nicholson (1984) also proposed that personal development and role development were combined to create four modes of work adjustment:

1. Replication (low personal change, low role development) where one performed in much the same manner as previous jobs.
2. Absorption (high personal development and low role development) where the burden of adjustment was borne almost exclusively by the person.
3. Determination (low personal development and high role development) where the burden of adjustment was borne almost exclusively by the organisation.
4. Exploration (high personal development and high role development) where there was a simultaneous change in personal and role attributes.

Nicholson suggested that the way people adjusted to a new role was a function of the requirements of the role, the motivational orientation of the individual and the socialisation practices, both formal and informal, in the organisation. Role requirements were moderated by discretion (i.e. the latitude to alter the task-related characteristics) and novelty; i.e. the degree to which the role permitted the use of prior knowledge, skills and habits. Motivational orientations are the desire for control and the desire for feedback. The aspects of socialisation considered were prior occupational socialisation and the formal organisational induction–socialisation processes for the new role. The Nicholson model has been tested on a number of occasions.

West et al. (1987), in a study involving British managers, investigated transitions into newly created jobs — jobs for which there were no incumbents. The character and outcomes of these moves were related to Nicholson's (1984) model of work-role transitions. Generally, support was found for the model, but pre-transition anxiety influenced the desire for a feedback component in the model.

Other findings suggested that those entering newly created jobs tended to receive less help. Socialisation patterns tended to be individual, informal, random and disjunctive. While this is likely to encourage role innovation, it is also likely to increase levels of anxiety. Newly created jobs may present opportunities for growth, exploration and job satisfaction; they may also present an overload of novelty and change. The need for feedback and support

was apparent. West et al. also found that the experience of innovation in a new role has the effect of amplifying individual growth needs, notably in those who have moved into a newly created job with a new employer.

West and Rushton (1989), in a study of student nurses, found high levels of personal change and low levels of role innovation in the response to the high novelty and the low discretion of hospital-based nursing training, consistent with Nicholson's (1984) model of work-role transitions. Contrary to the model's predictions, however, this research found that a high desire for control was also associated with high levels of personal change. It was suggested that there might be some atypical characteristic of student nurses or their job that have influenced the data.

A longitudinal examination of the Nicholson model (Ashforth and Saks, 1995) found only mixed, moderate support for it. It was argued that considering newcomer desires that are aroused by situational specific cues could enrich the model. Personal and role developments were seen as interacting, rather than independent, processes. The importance of the influence of social referents on role transitions was also identified.

In a similar study (Black, 1988) found that the variables hypothesised in the Nicholson model may only be moderate predictors of the changing self or job as modes of adjustments for new hires. Both these studies used newly graduating students entering their first professional employment as the research sample. It may be argued that these investigations measured life transitions as much as they measured work-role transitions.

Ashford and Taylor (1990) proposed a model of individual work adaptation that emphasised individuals' active attempts to engage and structure their work environments. Effective adaptation was viewed as an interactive process of compromise between the individual and the organisation that resulted in new behavioural routines. Secondary outcomes were expected to be high levels of performance, satisfaction, affective commitment and low levels of stress. In order to achieve effective adaptation, individuals

must meet three simultaneous requirements and accomplish four primary tasks. The requirements included:

- adequate information about the expected performance standards in the organisation;
- adequate internal conditions for the individual, needed for an appropriate response; and
- sufficient flexibility and freedom to allow for the acquisition of new behaviours and work habits.

The adaptation tasks were:

- sensemaking (acquiring a perspective of the situation);
- decision making (the recognition of discrepancies between the organisational demands and personal preferences);
- behaviour regulation (responding appropriately to organisational cues);and
- stress management (the individual's active attempts to manage their stress during adaptation in order to accomplish the three previous tasks).

Thus the individual was seen as an active participant in the adaptation process.
A literature search did not reveal evidence that the model had been tested. Several studies, however, explored components of the model. The requirements suggested by Ashford and Taylor (1990) were explored in the literature related to person–organisational fit. Personal–organisational fit was defined as the congruence between the norms and values of the organisation and the norms of the individual (Taylor and Giannantonio, 1993).

Following a review of the literature in the area, Pervin (1989) reported that there was an exaggerated emphasis on either the individual or the environment. He concluded that these were useless controversies, and that there was now sufficient literature to support an interactionist perspective. Chatam (1989), however, argued that a true interactionist perspective was a rarity in organisational models as such a perspective required the collection of valid information about individuals and organisations and an examination of the impact individuals have on organisations as well as the inverse relationship.

Nevertheless, newcomer adaptation refined the fit between individuals and the employing organisations, either because individuals experienced some change in values in response to vigorous socialisation practices or because the organisations experienced changes in values and norms due to weak value sets or the individuals' high levels of personal control and power (Taylor and Giannantonio, 1993).

Bretz and Judge (1994) argued that the construct of person–organisational fit is not fully understood and suggested that there were many different attributes that might be examined in the pursuit of understanding. These writers suggested that the research revealed four general conceptualisations of fit based on the congruence between:

- individual skills, knowledge and abilities and the job requirements;
- individual value orientations and the organisational culture or values;
- individual needs and the organisational reinforcement systems and structures; and
- individual personality and the perceived organisational image and personality.

They further suggested that the assumption of congruence was not necessary when describing fit. The notion of simultaneous need has yet to be explored.

Black (1988) investigated work-role transitions in the case of an overseas assignment to Japan and viewed the transition in terms of a number of adjustments. The degree of adjustment was viewed as being both subjective (i.e. the degree of comfort the incumbent felt in the new role) and objective; i.e. the degree to which the person mastered the role requirements and was able to demonstrate that adjustments via performance. The mode of adjustment involved the manner in which the individual adjusted to the new role, either by altering the new role to match themselves or by altering their own attitudes and behaviour to better match the role expectations.

Another type of adjustment considered by Black was that of facet of adjustment, which related to adjustment to outside work factors such as cultural elements. Role ambiguity and role discretion was found to influence work adjustment. Pre-departure knowledge,

association with locals and the adjustment of the family were found to correlate with general adjustment.

Louis (1980) took a different approach to the experience of newcomers entering unfamiliar organisational settings by describing the experience in terms of coping or sensemaking. It was proposed that entry experiences were associated with change, contrast and surprise. Louis defined change as the objective difference between the old and the new setting and proposed that the more elements that were different in the new setting, the more things there were with which the newcomer potentially had to cope. This change often related to a change of role and a change in professional identity.

Contrast, the second feature, was related to features or cues that come to the attention of the newcomer in the new setting. Contrast was person specific rather than indigenous to the organisational transition. Louis also identified a special case of contrast associated with the process of the letting go of old roles. She proposed that the newcomer evaluated aspects of the new role using old-role experiences as anchors on internal comparison scales. Alternatively, the newcomer may attempt to incorporate aspects of the old role into the new role or resist the new role in favour of the old role.

The third feature of the entry experience proposed by Louis (1980) was surprise, which was described as the difference between the individual's anticipations and their subsequent experiences in the new setting. The subject of the anticipation, and therefore the surprise, may be the job, the organisation or perceptions of personal performance. Louis describes several forms of surprise:

- Conscious expectations were unmet.
- Conscious and unconscious expectations of personal performance were unmet.
- Unconscious job expectations were unmet or features of the job were unanticipated.
- There were difficulties in accurately forecasting internal reactions (feelings) to a particular new experience.

- Cultural assumptions brought from previous settings as operating guides failed in the new setting.

Louis (1980) described the response to these surprises in terms of coping or sensemaking. Sensemaking was based on the assumption that coping was guided by cognition rather than preprogrammed scripts. Conscious thinking was necessary in novel situations, when outcomes were not as anticipated. The discrepancy between predicted and actual outcomes (i.e. between anticipations and experience) produced a state of tension that demanded a response. According to Louis, the individual needed to develop explanations for why the actual outcomes occurred rather than the predicted outcomes. The retrospective explanations resolved the state of tension, and it was this cognitive process that Louis labelled sensemaking.

The notions of surprise and sensemaking in relation to newcomer socialisation proved to have a significant impact on the thinking about work-role transitions (Saks and Ashforth, 1997). The relationship between socialisation practices and individuals' adaptation efforts and the overall process through which it occurred remains fairly hazy, however (Taylor and Giannantonio, 1993).

It does seem likely, as George (1993) argued, that a single model applied to an entire class of transitions (in this case, workplace transitions) was doomed to failure. Bretz and Judge (1994) agreed that the vast majority of the research suggested that transitions were too heterogeneous and too dependent on context to be captured by a single generic model. It was preferable to focus on relationships between characteristics of the person, task demands and environmental characteristics, rather than trying to identify traits that may be considered applicable for all people and for all circumstances (Pervin, 1989). The relationship between the person, the task and the organisational environment, with respect to those assuming new roles, appeared to be significantly affected by the roles they were required to undertake, the socialisation they received and the people with whom they interacted.

Models of work–role transitions have proven disappointing. In addition, in the case of the clinician manager who is required to undertake the amalgamation of two roles in a previously untried way, the application of generic models of work–role transitions appear limited, conceptually and practically, in their ability to explain the experience. The studies and approaches yielded from the literature indicate that the concept of role is a central and important issue, and obtaining insight into the role is therefore a more logical beginning.

3.6 Role theory

Role theory is concerned with the study of behaviours in a given role or under what circumstances certain types of behaviour can be expected (Hardy and Conway, 1988). Biddle (1986, p. 64) contended that roles are linked to structural positions within an organisation and suggested several underlying propositions:

- Some behaviours are patterned and are characteristic of people within contexts.
- Roles are often associated with groups of people who share a common identity.
- People are often aware of role, and to some extent roles are governed by this awareness; i.e. by expectations.
- Roles persist, in part, because of their consequences and because they are often embedded within larger social systems;
- People must be taught a role (i.e. socialised) and may find either joy or sorrow in its performance.

The term "role" has had exceptionally diverse usage. Hardy and Hardy (1988) suggested that the term has been used to indicate expectations (i.e. prescriptions, proscriptions or demands), descriptions, evaluations, behaviour and actions. Role was also used to refer to overt and covert processes. The term was commonly used in the literature to refer to both the expected and the actual behaviours associated with a position. As pointed out by Flynn (1998), psychologists viewed role on a personal, micro level, while sociologists and anthropologists focus on the overt, macro and societal levels of role.

Conway (1988) described two major perspectives from which role and role performance can be studied, and these are described in the following sections.

3.6.1 The functional/structural perspective of roles

The functional/structural perspective holds that organisations arise in society because they fill a need of that society (Conway, 1988). The division of labour within a given society is considered an expression of its state of development; and the more developed the society, the more complex are its structures and the more differentiated its labour force (Durkheim, 1964).

Durkheim (1964, p. 147–73) made the analogy between the cohesiveness engendered by the division of labour and that which is characteristic of a biologic system. Just as biological functionalism explains the way organs of the human body are structured so as to contribute to human well being, so functionalism explains social structures by their functions; that is, their contribution to the well being of society (Donaldson, 1996).

This approach described organisations as purposeful systems directed to the achievement of collective goals requiring structured coordination and control (Reed, 1992). The theory was articulated in relation to supra-individual structures and processes that met this functional need for regular coordination and control, describing the varying relationships between internal structural design and external environmental contingencies. Fit was the underlying key (Donaldson, 1996), and the emphasis was on adaptation by the organisation to its environment. Burrell and Morgan (1979, p. 26) summarised the characteristics of the functional/structural perspective like so:

> It is characterised by providing explanations of the status quo, social order, consensus, social integration, solidarity, need satisfaction and actuality. It approaches these general sociological concern from a standpoint which tends to be realist, positivist, determinist and nomothetic.

From the functional/structural view of society, roles — as well as organisational culture and norms — were treated as social facts that are transmitted to each succeeding generation in the process of socialisation as objective, real entities (Berger and Luckman, 1966). If

roles are constructed as social facts, the behaviour of actors could be considered structurally determined by the social forces dominant in a given society at any one point in time (Bandura and Walters, 1963). While sanctions may be imposed for behaviour that violated social norms, a consensual acceptance of these norms was the strongest force for maintaining adherence to them (Durkheim, 1964). Thus roles were seen as the primary mechanism serving essential functional prerequisites of the social system.

The functional/structural perspective assumed that roles are fixed in society and had certain expectations and demands attached, and that role behaviour is a response to what the situational norms demanded. People act in a learned response on the basis of a generally objective reality. It may be argued, however, that the functional/structural perspective does not account well enough for the wide variations in behaviour that are seen in complex social structures. Presumably, if social structures alone were the underpinning determinants of behaviour, all social action could be explained or predicted on the basis of the norms governing the society in question. This view of human nature would suggest that people respond only to objects in the environment without attaching any meaning to them (Conway, 1988). As pointed out by Mayhew (1980), the functional/structural perspective does not attribute social or psychological characteristics to an individual.

3.6.2 The symbolic/interactionist perspective of roles

In contrast to the functional/structural perspective, the symbolic interactionist perspective of roles focuses on the meaning that the acts and symbols of actors in the process of interaction have for each other (Conway, 1988). This perspective draws on the work of Blumer (1969). Human beings are seen as interpreting or defining each other's action, rather than just reacting to each other. Responses to the actions of others are not made directly to the action, but rather are based on the meaning that they attach to such actions. Thus human interaction is mediated by the use of symbols (for example, language), by interpretation and by ascribing a meaning to each other's actions. Symbolic interactionism involves not responding to the physical stimuli emanating from the other person, but by interpreting the meaning of their actions and, in turn, acting in a way one believes will be interpreted in a certain way by the other (Ashworth, 1979).

Zurcher (1983, p.13–14), following an extensive review of the literature, identified the basic assumptions of symbolic interactionism pertinent to the understanding of social roles. In summary, these assumptions were:

- Individuals not only conform to role expectations but consciously, purposively and actively interpret, organise, modify and create them.
- Human beings communicate with complex systems of symbols, most notably language. This allows individuals to share with others their understanding of the meanings of roles. Language, using names and labels, summarises understanding and enables communication with others.
- Understanding of roles is developed in a social situation and involves interaction with other people. Roles are specific to a setting, but the accumulation of experiences associated with different roles shapes self-concept. Self-concepts provide a sense of personal continuity over a number of roles in diverse social settings.
- some roles embedded in organisations are not very flexible; nevertheless, individuals find ways to enact even the most rigid roles in a manner consistent with their self-concept and their interpretation of the social environment. If a role is only vaguely defined in a social setting such as an organisation, self-concept and interaction with others establish a workable role;
- Individuals constantly try to find a way to merge their desires with what is expected in the specific role setting.

Table 3.5 summarises the viewpoints of these two major perspectives from which roles and role performance have been studied in the behavioural sciences.

Table 3.5: Two perspectives of social interaction (adapted from Conway, 1988)

Functionalist perspective	Symbolic interactionist perspective
Objects and people are stimuli that act on the individual.	An individual constructs objects on the basis of ongoing activity and gives meaning to objects and makes decisions on the basis of personal judgement
Action is a release or response to what the situational norms demand.	The individual decides what to do and how to do it, taking into account external and internal cues, interpreting their significance for action
Environmental forces act to 'produce' behaviour.	By a process of self-indication, an individual accepts, rejects or transforms the meaning (impact) of such forces.
Prescriptions for action, or norms, dictate appropriate behaviours. They are social facts.	Others' attitudes are the basis for individual lines of action.
An act is a unitary, bounded phenomena; i.e. it starts and stops.	An act is disclosed over time and what the end of the act will be cannot be foretold at the start.
The act (of an actor) will be followed by the response of another with or without any interpretation taking place on the part of the other.	An act is validated by the response of another.
People act on the basis of a generally objective reality; i.e. learned responses.	Reality is defined by each actor; one defines a situation as 's/he sees it' and acts on this perception.
Group action is the expression of societal demands and shared social values.	Group action is an expression of individuals confronting their life situation.

To further this discussion, it is necessary to place the study of roles in the organisational context.

3.6.3 Organisational perspectives of role theory

The inquiry into role in the organisational context has been a relatively late occurrence. Hales (1986), following a review of the literature on managerial jobs and managerial behaviour, suggested that role theory has much to offer as a theoretical approach. He argued that role theory is located at the intersection of individual and organisational behaviour, which makes it useful for analysing both the influence of expectations on managerial behaviour and the effect of individual actions and preferences on that behaviour.

The work of Katz and Kahn (1978) has been generally accepted as the beginning of such inquiry. They proposed that the contrived nature of human organisations and the unique property of a structure consisting of acts or events impacted on the roles within the organisation. Roles were therefore related to the position in the organisation rather than the individual personally. The roles people play were more a function of the social setting than their own personality characteristics. Expectations are the main elements in maintaining the role system and inducing the required role behaviour (Katz and Kahn, 1978 p190). The role set, the different people with whom the manager has contact and who have a stake in and hold expectations about the manager's performance in the job, are seen as 'role senders' and the manager as the "role taker". Role sending and role behaviour are seen as being an ongoing, interdependent cyclical process. Katz and Kahn appear to conceptualise roles in organisations from the structural/functional perspective (see previous discussion). Their theoretical perspective is summarised in Figure 3.1.

There are, however, indications that Katz and Kahn (1978) were moving away from the totally reactive point of view of the structural/functional perspective. They suggested that the role taking process did not occur in isolation but was moderated by the characteristics and expectations of the individuals, the communication process and the organisational context. As can be seen in the model, they suggested that some traits of people tended to evoke or facilitate certain evaluations and behaviours from role senders. The same role can be experienced differently by different people, and personality factors act as conditioning variables in the relationship between the role as sent and the role as received and responded

to. They further proposed that role behaviour has effects on personality. Taking this view, personality becomes an intervening variable, affecting both the relationship between the person and the role sender and the person themselves.

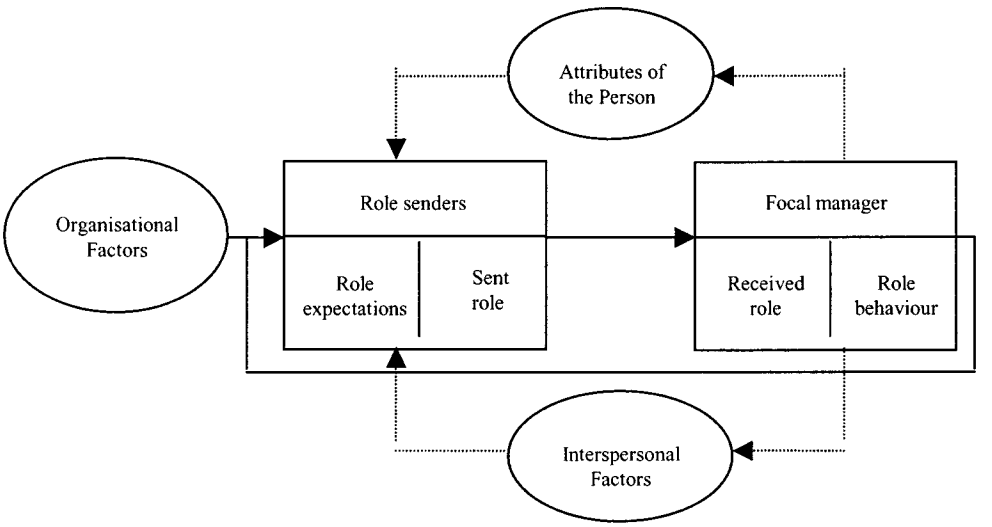

Figure 3.1: A theoretical model for factors involved in the taking of organisational roles (adapted from Katz and Kahn, 1978, p. 196)

The framework suggests that the manager faces an environment of role senders who hold expectations about appropriate behaviour, send signals to communicate these expectations, and react to the manager's behaviour with rewards and punishment. Fondas and Stewart (1994, p. 870) argued that this conception of role behaviour was too deterministic, portraying managers as "puppets in a puppet show, with hundreds of people pulling strings, forcing them to act one way or another". Rather, they contended, the manager can influence their role sets, and therefore the manager's role is enacted. The word "enactment" captures the notion of a manager actively, deliberately creating the environment rather than solely responding to it (Fondas and Stewart, 1994, p. 88). This is congruent with the symbolic interactionist perspective that saw role expectations and behaviours as being adjusted in the course of interaction in an evolving, dynamic process of negotiation and mutual influence. (See the previous discussion.) Symbolic interactionism was considered an appropriate paradigm in which to place the current investigation. A more extensive

review of the symbolic interactionist viewpoint and its place in organisational research was undertaken.

Section 2

3.7 Symbolic interactionism

Symbolic interactionism was a label created by Blumer in 1937 to describe the work of G.H. Mead, W.I. Thomas, C.H. Cooley and others whose philosophy and practice formed the basis of symbolic interaction (Lal, 1995). Although symbolic interactionism may be described as an American invention, its heritage can be traced back to Darwinian evolution, German idealism, Scottish moral philosophy and American pragmatic philosophy — principally J. Dewey, C. Pierce and W. James (Hammersley, 1989). Within symbolic interactionism there have developed different perspectives and orientations, dependent on the background of the author. The main variations can be traced to the Chicago School (H. Blumer), the Iowa School (M. Kuhn) and the dramaturgical approach (E. Goffman). Over time, symbolic interactionism has undergone a number of changes in perspective. As Fine (1993) reported, contemporary researchers claiming to be symbolic interactionists, blend their interest in classical "interactionism" with virtually all sociological traditions.

Rather than a unified theory, symbolic interactionism offers a theoretical perspective for the understanding of human experience. This presents problems for researchers using this framework as there is a lack of conceptual clarity or even a standard methodology. The deficit in precision is partially due to the diversity of original contributors, the oral tradition of symbolic interactionism and its emphasis on real-world processes (Ashworth, 1979; Rock, 1979).

Nevertheless, there remains components of interactionism that most who affiliate with the perspective hold to — notably a broad acceptance of Blumer's (1969) three premises of symbolic interaction:

- Human beings act towards things on the basis of meanings that they have for them. These things may be objects, other human beings, institutions, guiding ideals, activities of others and situations, or a combination of these.
- Meanings of such things are derived from, or arise out of, the social interactions that one has with others.
- These meanings are handled in, and modified through, an interpretive process used by the person in dealing with things encountered.

These premises rest on the belief articulated by Blumer (1969, p. 77) that:

> The human being is not just a responding organism, only responding to the play of factors from his world or from himself; he is an acting organism who has to cope with and handle such factors and who is so doing has to forge and direct his line of action.

Drawing from these premises, the main principles of symbolic interactionism may be described. These principles generally emerged from the Chicago School and reflect the work of Mead, Blumer, Glaser, Strauss and others.

Mind

Mead (1936) posited that the mind represented a process of adjustment or problem solving that transcended basic sensory capabilities in the here and now. At the centre of the adjustment process were selves who had the capacity to see themselves as others saw them. Individuals could engage in the process of self-correction and adjustment by indicating to themselves how to act further on the basis of environmental stimuli. Mind was engaged when a person involved in a social process became self-aware and aware of others and modified their reactions and interactions because of this reflective process (Harvey and Katovicj, 1992).

Self

The concept of self is developed through the social interactive process. Role taking is the basic underlying process through which self is developed. Role taking refers to the process through which an individual imaginatively constructs the attitudes of another and thus anticipates the behaviour of that person (Lauer and Handel, 1983). By taking the role of a

generalised other, the person forms an image of the type of person they (themselves) are. This self-image continues to develop over time as their impression of the generalised other changes and situations are redefined (Blumer, 1969). Self is a process, ongoing and iterative. The generalised other is an abstract summation and embodiment of all the varied replies that have been received by the individual. It represents a kind of condensed general will that responds to the individual's performance (Rock, 1979). The clarity, authority and structure of the generalised other will depend on the unity and connections of the groups though which a person passes.

Self has two components, the "I" and "me" (Mead, 1934). The "I" appears in the memory of the person, and is the form of "me" in the historical context (Blumer, 1969). Mead defined "me" as "... the organised set of attitudes of others which one himself assumes. The attitudes of others constitute the organised 'me', then one reacts to that as an 'I'." (p. 175). The "me" can represent the generalised other or the expectations of the social environment, and is the part of self that is responsible for self-control. Generally human acts start with the "I" and finish with the "me" — the "me" establishing the limits within which the "I" must act. (Reynolds, 1993). It is, however, possible, as Mead points out, for the individual to deliberately decide to act against the social attitudes that constitute the "me".

Associated with the notion of self, both as a process and an object, is that of self-image and how individuals present themselves in daily life. Strauss (1962) described how individuals to make sense of past experiences in light of their current perception of themselves. This perception of self can, and does, change following life events or critical incidents, requiring individuals to reorder their thoughts of the past.

Situation

The Chicago School of symbolic interactionism views society as an interactive process that is in a continual state of definition and redefinition by the individuals in it. The social collectives that make up society consists of individuals aligning their actions to the actions of others by ascertaining what they are doing and what they intend to do (Blumer, 1969).

The processes of role taking, self-indication and socialisation are integral to the maintenance of society.

Self-indication is a "...moving communication process in which the individual notes things, assesses them, gives them meaning and decides to act on the basis of that meaning" (Blumer, 1969, p. 81). When a thing is self-indicated it becomes an object to the individual and has a mental construction of meaning associated with it.

Socialisation is the process by which the individual learns to participate effectively in social collectives (Woods, 1992). This requires them to understand the symbolic environment of the individuals with whom they mix. This understanding is acquired through the interactive process, a major form being role taking. Mead (1934) considered role taking to be the basis of society. If an individual is not certain how to act in a certain context, they look to others for cues. The understanding of how to act, grows, changes and develops as the interaction continues. As individuals are socialised, they learn the collective understandings and patterns of conduct prevalent in the societies to which they belong. By interacting with the members of the role set, the individual can learn the particular meanings, attitudes and behaviours that are significant for that social collective (Lauer and Handel, 1983). The process of socialisation is an ongoing process, with the individual being socialised by the social collective and, in turn, acting as a socialising agent on the group.

3.7.1 Symbolic interactionism in organisations

Given the organisational context of the research, the work of Burrell (1979), applying sociological paradigms to organisational analysis, proved instructive. Based on the notion that all theories of organisation are based on a philosophy of science and a theory of science, Burrell and Morgan (1979) categorised different approaches to social theory in terms of two key dimensions of analysis — each of which, they believed, subsumed a series of related themes. These were a subjective–objective dimension and an assumption about the nature of society in terms of regulation–radical change dimension. This resulted in four paradigms as shown in Figure 3.2.

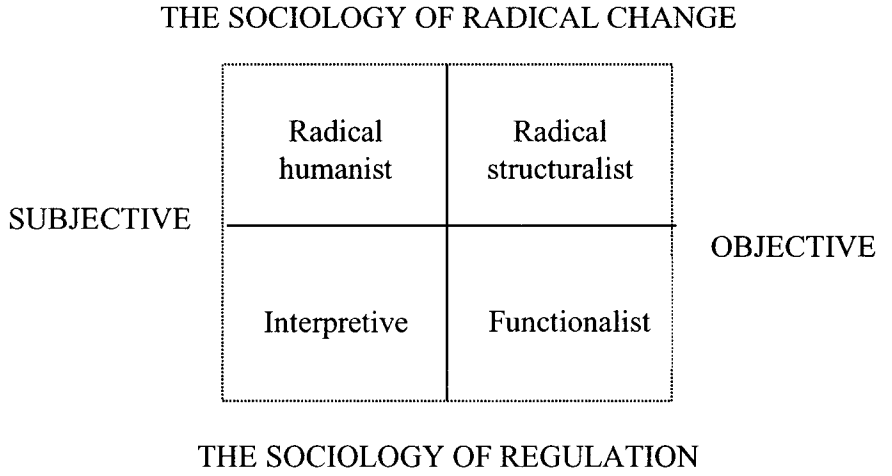

Figure 3.2: The four paradigms for the analysis of social theory (adapted from Burrell and Morgan, 1979, p.22)

Although there has been criticism of the dimensions (see Connell and Nord, 1996, for an overview of this argument), Burrell and Morgan made a significant contribution to changing the direction of research in organisational studies, opening the door for alternative approaches (Clegg and Hardy, 1996a).

According to Burrell (1979, p. 28) the interpretive paradigm is " informed by a concern to understand the world as it is, to understand the fundamental nature of the social world at the level of subjective experience". The interpretive paradigm provides an appropriate theoretic perspective from which to investigate the role of the clinician manager. Symbolic interactionism falls in the interpretive paradigm (Burrell and Morgan, 1979).

In summary, the symbolic interactionist perspective stresses the role of the individual actors and the evolution of roles through social interactions. Actions are validated through the responses of others, and others' attitudes are the basis for individual lines of action. Reality is defined by the perception of each actor. Symbolic interactionists focus on the ways individuals negotiate emergent meanings to discover and enact new roles based on their subjective interpretations.

Symbolic interactionism was chosen as the theoretical framework for this research as it offered a way of understanding the world from the view of the clinician managers. It placed an emphasis on the social process and the research subjects interpretation of the situation. Symbolic interactionism, however, offers a theoretical perspective for the understanding of human experience rather than a unified theory. This presents problems for researchers using this framework as there is a lack of conceptual clarity or even a standard methodology. It was, therefore, appropriate to chose a framework within the context of symbolic interactionism that would direct the inquiry into the role of the clinician manager. Such a framework is offered by sensemaking. Sensemaking, grounded in the field of organisational psychology, also places the research in the organisational context, rather than a broader milieu of society.

3.8 Sensemaking

Sensemaking is defined as an interpretative process in which people assign meanings to ongoing occurrences (Gioia and Chittepeddi, 1991; Weick, 1995). Sensemaking is a response to situations involving uncertainty and arousal (Erera, 1992; Gioia and Chittepeddi, 1991). Situations of ambiguity and uncertainty, where two or more prospective meanings appear clearly applicable and equally valid, serve as a sensemaking stimulant. Individuals search for evidence favouring one prospective meaning over others (Wagner and Gooding, 1997).

Murnighan (1993) describes sensemaking as a counter-intuitive theory because it does not reiterate common sense. Rather, it attempts to describe a more elaborate and deeper understanding of complex social phenomena, widening the disparity between what individuals intuitively expect and what actually happens. Nord and Fox (1996) describes the work of Weick (1979; 1993b; 1995) in the areas of sensemaking as leading away from the assumed concrete entities of the past. Symbolic interactionism is described as the "unofficial" theory of sensemaking because the framework keeps in play a crucial set of elements including sense, action, interaction, interpretation, meaning and joint action (Weick, 1995).

There appears to be some lack of clarity in the literature regarding sensemaking as a theoretical process. To illustrate, some researchers (for example Silvester, Anderson and Patterson, 1999; Silvester and Chapman, 1997; Wagner and Gooding, 1997) use sensemaking as an adjective describing an attributional process. Others (for example Gioia and Thomas, 1996; Thomas, Clark and Gioia, 1993) use interpretations as a synonym for sensemaking. Louis (1980) and Weick (1995) both argued that these viewpoints were based on the assumption that there is some kind of "text" or right answer in the world, waiting to be discovered and approximated to the current situation. While accepting that both interpretation and attributional processes are a part of sense making, Weick (1995) posits that these approaches miss part of the larger picture. For example, they fail to specify how the cues to which the individual is responding are singled out for attention from an ongoing flow of experience. Also unspecified is how interpretations and meanings of these cues are altered and made more explicit. He argued that problems do not present themselves as givens, but rather must be constructed from situations that are often puzzling, ambiguous and confusing. Louis (1980) also argued that sensemaking is a process of conscious thinking and a response to novel situations. People do not always recognise situations as novel and think and act accordingly. Weick (1979) argued that to understand sensemaking is to address the question of what provokes cognition in organisations.

Weick (1995) suggested that a crucial element of sensemaking is the notion that although situations are progressively clarified, the clarification often works in reverse. Rather than the outcome fulfilling some prior definition of the situation, it is more that the outcome develops that prior definition. The notion that outcomes develop prior definitions of the situation has roots in cognitive dissonance theory (Festinger, 1957). Aronson (1976) described dissonance as a negative drive state that occurs whenever an individual simultaneously holds two cognitions (i.e. ideas, beliefs or opinions) that are psychologically inconsistent. Since the occurrence of dissonance is presumed to be unpleasant, individuals feel pressure to reduce or remove it thus restoring consistency or consonance. Consonance may be achieved by changing behaviour, trivialising the dissonance or changing attitudes (S. Taylor, Peplau and Sears, 1997). These approaches, according to Weick (1995) are evident in the notion of sensemaking where post decision

outcomes are used to construct predecisional histories. Action may precede cognition, and cognition is shaped by the action or behaviour. To engage in sensemaking is to construct, filter, frame and render the subjective into something more tangible. When people make retrospective sense of the situations in which they find themselves, one of the tools that they use is their personal schema.

3.8.1 Schemas[1]

When individuals are confronted with ambiguous events, they struggle to make sense of them. Assigning meaning or sense to the situations allows the individual to act. Thus sensemaking is the primary generator of individual action (Drazin, Glynn and Kazanjian, 1999) The meanings that individuals hold have been labelled schemata scripts, (Gioia and Manz, 1985), cognitive maps (Porac, Thomas and Baden-Fuller, 1989) and schemas (Harris, 1994; Markus, 1977).

Schemas are one of the areas in the study of social cognition that has received considerable attention (Tenbrunsel, Galvin, Neale, and Bazerman, 1996). Fiske and Taylor (1991) suggested that schemas constituted a knowledge structure that, when evoked, influenced social judgements, behaviour and responses by that individual. Person schemas were believed to represent classifications that contain a good deal of information about traits, preferences and goals that enable the perceiver to understand exhibited behaviour, predict future behaviour and develop appropriate responses (Bazerman and Carroll, 1987).

Sims and Lorenzi (1992) described schemas in terms of person schemas, containing features and attributes that are associated with category membership; event schemas, behavioural scripts tied to specific situations; role schemas, for role prototypes; and self schemas, generalisations about the self, abstracted from the present situation and past experiences. Schemas, therefore, refer to the dynamic cognitive knowledge structures regarding specific concepts, entities and events used by individuals to encode and represent incoming information efficiently and are generally conceptualised as subjective theories

[1] More correctly, the plural form of schema is schemata, but the anglicised plural schemas will be used, in keeping with much of the literature cited.

derived from one's experiences about how the world operates (Markus, 1977). Schemas serve as mental maps that direct the search for and acquisition of information and guide subsequent behaviour in response to that information (Harris, 1994). Taylor and Croker (1981) (in Harris, 1994, p. 310) identified seven functions of schemas. They:

- provide a structure against which experience is mapped;
- direct information encoding and retrieval from memory;
- affect the efficiency and speed of information processing;
- guide "filling in the gaps" in the available information;
- provide templates for problem solving;
- facilitate the evaluation of experience; and
- facilitate anticipations of the future, goal setting, planning and goal execution.

Harris (1994) suggested that when a stimulus is encountered in the individual's environment, it is matched against a schema. The elements of the stimuli are imposed on the elements of the schema, which — in turn — outlines of expectations within certain ranges of acceptability. If information is missing, default values may be inserted, allowing the perceiver to go beyond the information given. This filling in of information offers a more complete perception than would other wise be possible but increases the potential for making incorrect assumptions about the stimulus (Harris, 1994).

Bartunek and Moch (1987) suggested that schemas may be expanded and elaborated as they incorporate new information. Over time, as more stimulus information is encountered, the schema for that stimulus becomes more complex, abstract and organised (Fiske and Taylor, 1991). The development of expertise results in the development of highly elaborate schemas drawn from the information of many experiences. This development of schemas has been labelled as a "first order" change (Bartunek and Moch, 1987).

When the information or experience conflicts with the knowledge of an individual's schemas, this new information is either ignored as an aberration or cognitively recast to fit current schemas. Alternatively, the individual may modify their schema. Bartunek and

Moch (1987) have labelled this fundamental alteration of a schema a "second order" change. As Harris (1994) pointed out, however, it is important to recognise that the schema directed nature of the perceptual process lessens the frequency with which schema-inconsistent information is discovered. The very nature of schemas act to "ensure that drastic challenge to their validity seldom arises" (p. 311). Since schemas direct searches for information, it is likely that the information uncovered will reinforce these schemas.

To illustrate, Wagner (1997), following an investigation of managerial sensemaking, found that there was a tendency for individuals to attribute instances of personal success to internal, personal causes and attribute instances of personal failure to external, situational or environmental causes. Further, there was also a tendency for individuals, when interpreting the actions of others, to make causal explanations that differed markedly from those they produced when making sense of their own behaviours. Whereas individuals may attribute personal success to personal factors, they are more likely to attribute success in others to situational variables. Apart from the possible serious consequences for the organisation, overconfidence in "self" and underestimation of "other", illustrates the possible inaccuracies and biases in personal schemas.

Fiske (1993, p.182) argued that most people construct the meaning of their social environment well enough to enable effective actions; that is, their "thinking" is good enough to serve their "doing". Individual's uses of expectancies and data suits their purposes, given that they are also alert for incongruent and negative information. Accuracy is not absolute, and accuracy demands will be dependent on the purpose. Expectancy of outcomes (the self-fulfilling prophecy) and consensus are often used as a proxy for accuracy (Fiske and Taylor, 1991).

Further threats to the accuracy of schemas are proposed by Hill and Levenhagen (1995). First, schemas are not stable over time and what fits today may not do so tomorrow. Second, the cognitive short cuts that schemas often use (for instance, the use of metaphors and stereotypes), and which make them useful in practice, also limits their accuracy and precision. To add additional detail, however, may make the schemas of less value in articulating ambiguous situations. The incomplete nature of schemas may, therefore, be

both a strength and a weakness. Hill and Levenhagen also pointed out that expertise in establishing and implementing schemas may sometimes be limited by the cognitive ability of the individual.

3.8.2 Schema-driven sensemaking

Harris (1994) proposed that schemas guide organisational sensemaking on two fundamental levels. First, they facilitate answering the question "What or who is it?", which promotes the categorisation and identification of the stimuli. The second question is "What should I pay attention to?", which indicates that the search for meaning is egocentric. Gioia and Poole (1984) suggested that schema-driven sensemaking can occur both consciously and relatively unconsciously. Unconscious processing requires little choice or schema reconciliation and is usually associated with familiar and routine experiences. The degree of conscious processing required is primarily determined by the novelty of the experience and the demand for conscious reflective processing (Harris, 1994). Given their inexperience in the organisational setting or the new role, newcomers are likely to engage in conscious, reflective sensemaking (Louis, 1980).

Hill and Levenhagen (1995) suggested that mental models are necessary to cope with uncertainties (sensemaking) and to communicate with others (sensegiving). Metaphor development is proposed to be a significant and important stage in this process and provides a common language and a basis for communication in the organisation. The importance of metaphors in sensemaking have also been identified by Greenberg (1995). Hill and Levenhagen proposed that in the mental-models were selectively constructed, starting with an intuitive model based on a felt belief system. The capacity to verbally articulate these cognitions relies on the limited capacity of language. In order to explain a mental model, an individual uses metaphors — incomplete statements of one thing in terms of another. Individuals use metaphors even in conversations with self, especially when the amount of detail overwhelms cognitive abilities, when learning is incomplete, when perceptions seem ambiguous and when problem domains are ill-structured (Hill and Levenhagen, 1995). Formal models are developed and refined from metaphors and intuitive models. These are thought by the users to be objective, rational and to reflect an accurate representation of the world. In organisations, formal models often result in policies

and procedures that are intended to structure organisational processes. At any stage of development, mental models produce observable results and information (as a product of action or inaction) thus facilitating sensegiving. Weick (1979) described the process of taking the direct path from the intuitive-model stage to enactment as a component of retrospective sensemaking.

When discussing managerial sensemaking, Bayster and Ford (1998) suggested that the sensemaking process proceeds through three stages: scanning, interpretation and classification. This is similar to the stages of gestation, categorisation and diagnosis proposed by Cowan (1986) and that of noticing, interpreting and incorporating stimuli proposed by Kiesler and Sproull (1982). Scanning and searching involves the gathering of ambiguous information, reflecting both the cognitive framework (developed from education and experience) and the role schema (relating current organisational position) of the individual. The salience of cues will be dependent on individual perceptions. The information acquired will be interpreted following reference to personal schemas leading to the assignment of category labels to equivocal environmental information. Information is then classified according to the assigned category label. The classification of schemas in the context of sensemaking has received some attention in the literature. Classification has been understood in terms of threats and opportunities (Jackson and Dutton, 1988), issue importance (Kerr, 1992) and strategic or political priorities (Gioia and Thomas, 1996). It would appear that the classification process is situation specific.

The social-cognition literature has devoted little attention to the understanding of social sensemaking and how schemas are consciously manipulated to make sense of organisational experiences (Schneider, 1991). Harris (1994) suggested that the "mental debate" perspective offers insight into this process. Harris takes the view that in organisations, individuals enact their experiences and choose to behave in response to those experiences based on the outcomes of "contrived mental dialogues between themselves and other contextually relevant (past or present, real of imagined) individuals or groups" (p. 316). This mental dialogue process is likely to influence sensemaking in a relatively conscious and reflective manner when novel and unexpected social stimuli are encountered. Louis (1980) argued that newcomers enter organisations with a wealth of

schemas based on their previous experiences. They will develop new schemas particular to the new organisations based on conversations with themselves about the nature of the organisation, its people and how these stimuli impact on the role of the newcomer. Newcomers compensate for their lack of schemas by creating structures that make sense of the new situation. This sensemaking comes, in part, through communication with co-workers and is a social activity that is dependent on language for understanding. Weick (1995) argued that sensemaking is never solitary because what a person does internally is dependant on others. Even monologues and one-way communications presume an audience.

Research into schemas is difficult to design because of their subjective and abstract nature. The notion, however, is thought to be of importance when examining the enactment of the role of the clinician manager. The quite different perspectives of the clinician and the manager (see the discussion in section 3.3.2) represent different schemas. The clinician manager role would involve the conscious or subconscious integration of these schemas. The individual's experience of this process is central to the understanding of the adaptation to the role. Levels of analysis of schemas may provide insight into this process.

3.8.3 Levels of analysis

Because individuals develop and maintain subjective interpretations of their roles in organisations, different levels of analysis emerge (Drazin et al., 1999; Silvester and Chapman, 1997; Weick, 1979, 1993b, 1995).

These levels may be described as

1. Intrasubjective or intrapersonal, which reflect the individual's understanding of how his or her organisational environment is organised and can be biased by personal and social–psychological factors such as the desire to maintain self-esteem (Silvester and Chapman, 1997). An impact on disposition or personality is also likely (Fiske, 1993).
2. Intersubjective or interpersonal understanding is shaped by interactions with others who are engaged directly or indirectly in similar endeavours (Drazin et al., 1999). This may be related to causal explanations for another person's behaviour (Silvester and

Chapman, 1997). Even though two individuals may share a similar set of experiences, their frames of reference may differ based on their positions with respect to that activity. As a result, sensemaking may be marked by divergent and sometimes antagonistic frames of reference (Volkema and Farquhar, 1996; Weick, 1979)

3. Intergroup sensemaking relates to the interpretative schemas of different communities of specialists who literally think differently from each other (Dougherty, 1992). This introduces the notion of the collective mind in sensemaking, which is a dramatic shift in thinking about the mind (Nord and Fox, 1996). A collective mind is different from an individual mind because it belongs in the pattern of interrelated activities among people (Weick, 1993b). This notion has been used to describe professional culture in an organisational context (Bloor and Dawson, 1994).
4. Organisational sensemaking refers to a common understanding shared by groups of people. In the organisational context this perspective has been used to explain the development of organisational culture (Silvester et al., 1999) and sensegiving during strategic change (Gioia and Thomas, 1996).

3.8.4 Conflict in sensemaking

In order to account for what is being communicated in the sensemaking process, Weick (1995) introduced a new conceptual category, a "unit of meaning", defined as a "cue", plus "a relation" plus "a frame". This definition suggested an attempt to link the cognitive processes of organising to the social environment of the organisation (Magala, 1997). For Weick, frames of reference were determined by past socialisation, personal and professional experiences, and by more recent organisational experiences. Cues were any present events or problems that trigger sensemaking activities, requiring individuals or groups to relate present cues with previously formed frames of reference. Units of meaning were not communicated freely because some assumptions, and norms were taken for granted and conflict was often a result of the sensemaking process. One way of looking at the conflicts within sensemaking activities is to explain them in terms of struggles between and about various paradigms that are used by all members of the organisation (Magala, 1997). Paradigms, in this context, are about protocols of communicating, but their primary

function is to define and maintain mutual frames of reference (Weick, 1995). Paradigms should provide all members of an organisation with standard operating rules, shared definitions of their environment and with basic assumptions about power, authority and the procedures for applying them (Magala, 1997). Brown (1978) described a paradigm as a set of assumptions, usually implicit, about the nature of the world and the behaviour required.

At an interpersonal level, Volkema et al. (1996) suggested that sensemaking invokes complex social dynamics and is followed by a range of behaviours. Sensemaking is proposed to have three components: emotional, cognitive and behavioural. Individual psychological styles, the nature of the situation and the context, and the dynamic interactions among the components vary, which produces different sensemaking behaviours. Conflict can be both an antecedent and a consequence of sensemaking activities.

3.8.5 Properties of sensemaking

Sensemaking has been explored from a number of theoretical perspectives and employing a number or research methodologies. The most coherent explanation of the distinguishing characteristics that sets sensemaking apart from other explanatory processes is offered by Weick (2001) who suggested seven properties of sensemaking. Sensemaking can be understood as a process that is:

1. Social

Sensemaking is a social process as conduct is contingent upon the conduct of others, whether imagined or physically present. Symbolic interaction is an important part of sensemaking. Sensemaking is never solitary because what a person does internally is contingent upon others. Even monologues and one-way communications presume an audience. The study of sensemaking, therefore, needs to focus on talk, discourse and conversation as this is how a great deal of social contact is mediated.

2. Grounded in identity construction

Sensemaking processes are derived from the need within individuals to have a sense of identity, a general orientation to situations that maintains self-esteem and consistency of

ones' self-conceptions. Sensemaking is triggered by a failure to confirm one's self. Cues for identity are taken from the conduct of others, but individuals make an active effort to influence this conduct to begin with. Thus sensemaking is self-referential, and the establishment and maintenance of identity is an essential function.

3. Retrospective

The creation of meaning is a process of attending to cues in the environment, but the attention is to that which has already occurred. Occurrences in the present will be interpreted by what has occurred in the past. Thus sensemaking relies on memory and recall, which may be misleading.

4. Focused on and by extracted cues

Noticing refers to the activities of filtering, classifying and comparing. Sensemaking refers more to the interpretation and the activity of determining what the noticed cues mean. If cues are not noticed they are not available for sensemaking. The context will affect what is extracted as a cue in the first place and how the cue is interpreted.

5. Ongoing

Sensemaking has no clearly identifiable beginning or end. Experience is a continuous flow, and sensemaking is constrained not only by past events but also by the speed with which events flow into the past and interpretations become outdated.

6. Driven by plausibility

Sensemaking is about plausibility, pragmatics, coherence, reasonability, creation, invention and instrumentality. Due to information overload, accuracy of recall, time constraints, the nature of truth and the limited data processing of the human mind, sensemaking relates to interpretations that are sociably acceptable, credible and workable.

7. Enacted

Action makes it possible for people to say what they think; thus, people often produce part of the environment they face. People produce reality through authoritative acts; however, actions may not produce visible consequences. To do nothing may also be considered an action. In addition, actions may be inhibited, abandoned or redirected.

3.8.6 Research in sensemaking

Although the functionalist perspectives have dominated organisational research, a sensemaking perspective has made significant headway (Drazin et al., 1999). Nevertheless, despite sensemaking processes having been cited for their substantial theoretical importance, relatively little empirical research has investigated the proposed internal linkages (Milliken, 1990). Sensemaking has been criticised for its lack of conceptual coherence (Thomas et al., 1993) and for having an underlying research methodology that is invisible, incomprehensible, illegitimate or impractical (Pfeffer, 1995). The need for a more explicit research has also been identified by Orton (1997). It is clear that a significant research agenda remains but as Van Maanen (1995) pointed out, there is already a considerable body of research based in sensemaking.

A sensemaking approach has been used to explaining a number of organisational phenomena, including newcomer socialisation (Louis, 1980), problem sensing (Kiesler and Sproull, 1982), strategic management (Smircich and Stubbart, 1985), organisational change (Isabella, 1990), strategic change initiation (Gioia and Chittepeddi, 1991; Gioia and Thomas, 1996), image and identity (Dutton and Dukerich, 1991; Riley, 2000), disasters (Weick, 1993a), organisational culture (Thomas et al., 1993), professional culture (Bloor and Dawson, 1994), restructuring (Greenberg, 1995), entrepreneurial and innovative activities (Coopey, Keegan and Emler, 1997; Hill and Levenhagen, 1995), organisational conflict (Volkema and Farquhar, 1996), creativity in organisations (Wagner and Gooding, 1997) and human resource management (Watson and Watson, 1999).

Other research conducted has highlighted methodological issues. Thomas et al. (1993) investigated the strategic sensemaking processes of scanning, interpretation and action and how these activities are linked to organisational performance. The intention was to demonstrate the relationship between cognition and action. These activities were seen as important aspects of the more general notion of sensemaking. Scanning was defined in terms of data gathering, but it was assumed that that there is a selection process involved in attending to specific information. Interpretation was seen as an individual-level process in which people attend to and describe meaningful labels to incoming information. Action is

any significant change in ongoing organisational practice. The research, conducted in the health care industry, provided informants with two different case scenarios and then asked a series of questions regarding scanning and interpretation. Informants were then asked to respond to a questionnaire with items developed from the case study that were analysed quantitatively, and a model proposing relationships was developed. Findings demonstrated the complexity of linkages between sensemaking and performance and the intricate processes involved. Thomas et al. also suggested that the sensemaking processes are constantly changing as a result of the various processes used to negotiate them. Limitations in developing a descriptive model are apparent.

Gioia and Chittepeddi (1991) reported an ethnographic study of the initiation of a strategic-change effort in a large public university. Data was gathered via participant observation and in-depth interviews. The methodology was designed to provide a thick description of events and to allow for an alternative way of seeing the change. The approach applied a phenomenological richness by reporting direct evidence of emergent themes. Gioia and Chittepeddi suggested that the findings represented three different perspectives: a first-order view from the participant observer, a related first-order view based on the informants' perspectives and a second-order view from an outside researchers' perspective. The analysis suggested two major dimensions for an explanatory framework: sensemaking and sensegiving.

In the context of the study, Gioia and Chittepeddi described sensemaking as being related to the construction and reconstruction of meaning as the stakeholders attempted to develop a meaningful framework for understanding the nature of the proposed change. Sensegiving was concerned with the process of attempting to influence the sensemaking and meaning construction of others toward a preferred redefinition of organisational reality. The researchers found that these processes took place in an iterative, sequential and — to some extent — reciprocal fashion and involved all those associated with the change process.

Greenberg (1995) used case-study methodology to explore the sensemaking process around a departmental change. She found that because leaders did not explicitly direct

understanding, organisational members had to rely on the available symbolic processes to guide their development of their personal and shared understanding of the new order. A new reality did not simply exist following an organisational change but was created as the organisational members engaged in the sensemaking process. Greenberg described symbolic processes as "any action, phase, ritual, story or object that takes on a meaning that is much greater than the individual object" (p. 186). The symbolic process created a relationship between two situations, providing an unfamiliar circumstance with coherence and understanding by compressing meaning and enabling the articulation of abstract, ambiguous concepts. Symbolic processes, therefore, facilitated sensemaking and influenced perceptions of reality.

Gioia and Thomas (1996) investigated how top management teams in higher education institutions made sense of issues that affect strategic change. A two-phase research approach was used that progressed from a grounded theory model, anchored in a case study, to a quantitative generalisable study of the interpretation process. It was assumed that meaning was essentially a socially constructed phenomenon, and the interpretation system was treated as a subjective framework of understanding. The focus of the semi-structured in-depth interviews was the way individuals understood their context and experience and how they communicated that understanding among themselves and to others. Analysis of the qualitative data suggested that there were two dominating contextual influences on how top management teams made sense of issues important to the change effort, both of which were internal to the organisation rather than external as may have been expected. These internal influences served as both an attention directing device and a symbol of the university, as well as the top management team's information-processing structure that they used to deal with information on important issues. This led to a proposition that the perceptions of image and organisational identity partially mediated the relationship between the sensemaking context and issue interpretation. The sensemaking context impacted on perceptions, which in turn impacted on organisational issue interpretation.

These main concepts were incorporated into the research design and a questionnaire developed and distributed to a larger research sample (n = 611) (Gioia and Thomas, 1996).

The broadly based survey results offered general support for the grounded findings, demonstrating that image and identity have strong and systematic relationships with interpretations of key issues. Image and identity directly affected issue interpretation and served as links between the organisational sensemaking context and issue interpretation.

Silvester et al. (1999) proposed that organisational culture can be conceptualised as a dynamic product of collective sensemaking where individuals communicate and agree on common explanations for work-related events in an effort to understand, predict and control their environment. Spoken attributions were thought to represent a focus for exploring the extent to which members of a particular group share causal attributions. An empirical case study methodology was used to elicit and analyse a large sample of attributional statements made by individuals involved in a culture-change intervention. Results indicated considerable inter-group differences between managers, trainers and trainees in their cognitive maps as sensemaking heuristics. The research raised questions regarding the strength of culture, the homogeneity of in-group attributions and the possible influence of a powerful individual on which schema comes to be shared by other group members.

Wagner and Gooding (1997) investigated the attributional tendencies of managers under different sensemaking conditions. The primary purpose of the study was to investigate whether actor–observer effects could be detected in managers' interpretations of equivocal information. The methodology involved developing a business scenario and presenting this scenario to the research sample. Results were analysed quantitatively and indicated that managers receiving equivocal information about the performance of an organisation described as their own, credited positive outcomes to organisational strengths and blamed negative outcomes on environmental threats. In contrast, managers receiving equivocal information about an organisation described as managed by others, associated positive outcomes with environmental opportunities and linked negative outcomes to organisational weaknesses. Thus both self-serving and actor–observer attributional patterns were detected.

A coherent methodology for investigating sensemaking appears to be elusive. Sensemaking has generally been used a conceptual framework for the investigation of and an explanation

for other organisational constructs and processes. The research methodologies used have been diverse, influenced by the aims of the research and the context in which the research was conducted. Empirical research into the elements of the sensemaking process is marked by its paucity. The growing body of research using sensemaking as conceptual framework, however, attests to the utility of the process in contributing understanding to many aspects of organisational behaviour.

Sensemaking research is best understood by aggregating the findings reported in the literature. Weick (1995, p. 173), following a review of the diverse literature in the area of sensemaking, suggested that the majority of the studies shared several characteristics:

- Investigators make an effort to preserve action that is situated in context.
- Participants' texts are central, and there is less reliance on researcher-specified measures.
- Participants, rather than observers, define the work environment.
- Findings are described in terms of patterns rather than hypotheses.
- Explanations are tested as much against common sense and plausibility as against *a priori* theories.
- The density of information and the vividness of meaning are as crucial as precision and replicability.
- There tends to be an intensive examination of a small number of cases, rather than a large number of cases, under the assumption that person–situation interactions tend to be similar across classes of people and situations.
- Settings are chosen more for their access to the phenomenon than their representativeness.
- The methodologies chosen deal with meanings rather than frequency counts.

It may be concluded from this review that qualitative methodologies are considered by most researchers to be appropriate when investigating sensemaking.

3.9 Conclusions

The role of the clinician manager is of growing importance in health care systems worldwide. In response to health care reform initiatives, many clinical professionals are being required to take on general management responsibilities in addition to their clinical role. While clinicians have a long history of managing the delivery of clinical services, the assumption of wider organisational management responsibilities is a new trend. These changes are impacting on clinicians of all educational preparations, most notably medical practitioners and nurses. The role is poorly understood, however, and there is limited research in the area despite the apparent need. Recommended approaches to this research are work-role transitions and role theory.

The literature relating to research into work-role transitions, mainly aimed at producing a model of the process, has been largely disappointing. It has failed to consider both individual variations and, more importantly, the impact of context. Given the unique demands of health care organisations, the characteristics of the clinical professionals and the incomplete understanding of the clinical management role, it is unlikely that general management theories or the extant models of work-role transitions will adequately explain the dynamics of this new role. It is also likely that the role will develop differently, depending on the context.

Role theory offers another approach. The symbolic interactionist perspective of role theory stresses the role of the individual actor and the evolution of roles through social interaction. Interactionists focus on the ways that individuals negotiate emergent meanings to discover and enact new roles based on their subjective interpretations. Symbolic interactionism, however, offers a theoretical perspective for the understanding of human experience rather than a unified theory. This presents problems for researchers using this perspective as there is a lack of conceptual clarity. It was, therefore, appropriate to choose a framework within the context of symbolic interactionism that would direct the inquiry into the role of the clinician manager. Such a framework is offered by sensemaking.

Sensemaking, with its origins in symbolic interactionism, is resident in the field of organisational psychology thus placing the research in the organisational context, rather than a broader milieu of society. Although also criticised for a lack of conceptual clarity, there is a growing body of literature using sensemaking as a framework for understanding a number of organisational processes. Most of this research is characterised by the use of qualitative research methodologies. Sensemaking is defined as an interpretive process in which people assign meanings to ongoing occurrences. Central to sensemaking is the notion of schemas — the meanings that individuals hold. It is considered that sensemaking, with its conceptual underpinnings in symbolic interactionism, is an appropriate conceptual framework to drive an inquiry into the role of the clinician manager. The research methodology is described in Chapter 4.

Chapter 4: Methodology

4.1 Introduction

This chapter describes the methodology of the research; the research design, the qualitative research process, data collection methods and the approaches employed in data management and data analysis.

The broad aim of the research was to describe clinician managers' understandings of their role and the adaptation and enactment processes within that role. More specifically, the aim of the research was twofold. First, the aim was exploratory: to investigate the little understood clinician manager role and discover important categories that had meaning for the respondents. The second aim was explanatory: to explain emerging patterns related to the role and to identify plausible relationships shaping the role in terms of a theory.

4.2 Selection of the theoretical framework

It is generally accepted that the selection of the theoretical framework and research methodology should be derived from the issue under investigation (Denzin and Lincoln, 1994). This study required a theoretical framework that could examine and explain the process that clinical managers experienced as they sought to understand, adapt to and enact their new role. As this process was influenced by the operating environment — both organisational and societal — in which it was taking place, the theoretical framework needed to provide a conceptual lens through which these influences might be examined.

Following the support for the approach gained from the literature review (see Chapter 3), the research was set within the subjectivist, interpretive tradition of social science and founded within the symbolic interactionist paradigm (Blumer, 1969; Woods, 1992) . Sensemaking (Weick, 1995) was used to frame the inquiry. Because of this chosen

theoretical framework and the fundamentally interpretive nature of the research, qualitative research methodology was employed.

Leininger (1985, p. 5) described qualitative research as "methods and techniques of observing, documenting, analysing and interpreting attributes, patterns, characteristics and meanings of specific, contextual or gestaltic features of the phenomena under study". More succinctly, qualitative research may be described as "any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification" (Strauss and Corbin, 1990, p. 17). Creswell (1998) suggested that qualitative research is an inquiry process of understanding, based on distinct methodological traditions of inquiry. Typologies of qualitative inquiry are many and are dependent on the discipline of origin, the conceptual framework for the research and the focus of the inquiry (Rice and Ezzy, 1999). All methodological traditions in qualitative research, however, share underlying philosophical assumptions. Ontological assumptions, relating to the nature of reality reflects the notion that reality is subjective, as perceived by the participants in the study. In the relationship between the researcher and the research, there are attempts to reduce the distance and the objective separateness. These epistemological assumptions promote interaction between the researcher and the researched (Atkinson, Delamont and Hammersley, 1988; Creswell, 1998; Grbich, 1999; Hussey and Hussey, 1997). This requires the researcher to have "theoretical and social sensitivity, the ability to maintain analytical distance while at the same time drawing on past experience and theoretical knowledge to interpret what is seen, astute powers of observation, and good interactions skills" (Strauss and Corbin, 1990, p. 18).

Creswell (1998) recommended that the selection of an appropriate methodological tradition is best done by matching the central purpose or focus of the tradition with the purpose of the research. As the ultimate purpose of this research was to generate a substantive theory to explain the role of the clinician manager, grounded theory was chosen as the methodological approach. Grounded theory is also congruent with the symbolic interactionist paradigm in which the research is set.

4.3 Grounded theory

Grounded theory, as a method of qualitative research, was developed from the implications of the symbolic interactionist view of human behaviour (Chenitz and Swanson, 1986). The method systematically applies specific procedural steps to ultimately develop a grounded theory or theoretically complete explanation about the particular phenomena (Streubert and Carpenter, 1995). Strauss and Corbin (1990, p. 23) explained:

> A grounded theory is one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore, data collection, analysis, and theory stand in a reciprocal relationship with each other. One does not begin with a theory, then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge.

The goal of grounded theory investigations is the discovery of theoretically complete explanations about particular phenomenon. Strauss and Corbin (1990, p. 31) explained that grounded theory involved:

> Systematic techniques and procedures of analysis that enable the researcher to develop a substantive theory that meets the criteria for doing 'good' science: significance, theory observation, compatibility, generalisability, reproducibility, precision, rigor and verification.

Substantive theory is that developed for a substantive or empirical area of inquiry (Glaser and Strauss, 1967) and, as such, evolves from the study of a phenomena situated in one particular situational context (Strauss and Corbin, 1990). This is manifestly different to formal theory, which is developed for a formal or conceptual area of inquiry (Glaser and Strauss, 1967), and emerges from a study of a phenomena examined under many different types of situations. It is not the level of conditions that make the difference between substantive and formal theories, but the variety of situations studied. Substantive and formal theories are considered to be middle-range theories in that both types of theories fall between a working hypothesis and the all-inclusive grand theories (Glaser and Strauss,

1967). The underpinning notion of grounded theory is that it is based in inductive analysis, with the research proceeding from data to theory; i.e. method, data, findings, theory. This is opposed to deductive research methods that generally proceed from theory to data; i.e. theory, method, data, findings (Creswell, 1998).

The term "grounded theory" is commonly associated with its founders, Glaser and Strauss and their landmark publication "The Discovery of Grounded Theory" in 1967. Glaser and Strauss had felt the need to provide a counterbalance to the dominance of the "doctrinaire" concern in sociology with the rigorous verification of logically derived theories that had allowed the persistence of a perceived "embarrassing gap between theory and empirical research" (Glaser and Strauss, 1967 p. vii).

The foundations of grounded theory are theoretical sampling — a process by which respondent selection is controlled by the emerging data — and constant comparison, a method for joint data coding and analysis. Using the terminology of Glaser and Strauss (1967), the process of the methodology may be summarised as follows. Incidents of phenomena in the data are coded into categories. By comparing each incident with previous incidents in the same category, the researcher develops theoretical properties of the categories and the dimensions of those properties. As the study progresses, the focus changes from comparing incidents with one another with comparing incidents with the property of the category that resulted from initial comparison of incidents. Theoretical sampling and constant comparison processes lead towards theoretical saturation and a reduced set of categories within the boundaries of the emerging theory. Thus grounded theory is an iterative, highly personal procedure. Glaser and Strauss stressed the need for "theoretical sensitivity" (p. 46), claiming that following procedures is not the most important thing. More important is the combination of the researcher's innate ability to conceptualise and formulate theories, personality and temperaments, and knowledge of the area of research.

Since the publication of the original text, Glaser and Strauss have had a conceptual parting of the ways. Glaser has been more focused on ways of enhancing researchers' latent creativity, strongly resisting the move of grounded theory towards an orthodox

methodology. Strauss, on the other hand, was inclined towards producing prescribed procedures for the benefits of users of the grounded theory approach. Strauss and Corbin (1990) was an attempt to spell out the procedures and techniques in a step-by-step fashion. Glaser was horrified and said so very clearly (Glaser, 1992). Nevertheless, researchers struggling with some of the conceptual and procedural complexities of grounded theory have turned to Strauss and Corbin with a seeming sense of relief. Strauss and Corbin do not reject the principles of the original 1967 text in any way, but attempt to operationalise the method in a more procedural manner.

4.3.1 Grounded theory and management research

The application of grounded theory methodology in management research has proved to be problematic. Locke (1996) observed that despite the frequency with which Glaser and Strauss and the idea of grounded theory are cited in the literature, there are comparatively few instances of its application. Locke interpreted these ambiguous descriptions to mean that, while these articles may purport to use grounded theory methodology, most simply do not. Lee et al. (1999) reported that while many published articles appear to use grounded theory, few of these studies fully explain their application of the process. Partington (2000) suggested that whether or not grounded theory was used may be made uncertain by overly terse descriptions, an over-emphasis on one portion of the method and an under-emphasis on another, or an author's insufficient understanding of the methodology. Using qualitative methods to generate theory and a few references to Glaser and Strauss appears to have been sufficient for many writers to claim to have used grounded theory.

Nevertheless, grounded theory approaches have the potential to meet requirements for management research. In management research, theorists and practitioners operate in an environment of interdependence (Tranfied and Strarkey, 1998). Academics and managers work together in a circle of understanding relating to explanation and action.
This relationship is illustrated in Figure 4.1

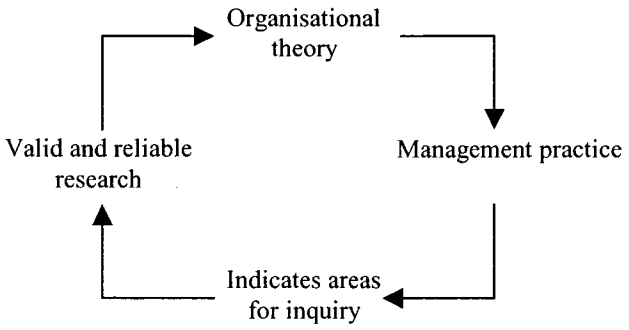

Figure 4.1: Relationships between organisational theory and management practice

Central to this proposition is the notion that organisational theory is of use in the "real world" of management practice, with a clear relationship demonstrated between the usefulness and the validity of the research. Some writers (for example Daft and Lewin, 1990) question the relevance of much of the organisational studies literature to managers as much largely ignores practical concerns. The need for the development of theory, which reflected the real world of the practicing manager, was identified.

There was also the argument that organisational research has placed too much emphasis on the building of new theories from empirical data and testing statistical significance of relationships between conceptual variables in theoretically based data (Mintzberg, 1979). Grounded theory methodology addresses both of these concerns and offers the opportunity to develop theory from the subjective experiences of practicing managers.

Despite the notion of grounded theory being intuitively attractive to management researchers seeking to understand novel and poorly understood management actions, the application of the methodology is difficult. Lee et al. (1999) ,when reviewing all studies in the fields of organisational and vocational psychology that claimed to use grounded theory, reported that although some articles were considerably better than others, none of the identified articles met the complete or "pure" spirit of grounded theory identified by Glaser and Strauss (1967) and Strauss and Corbin (1990). This finding seems to indicate serious

problems with the use of grounded theory methodology in management studies. It is likely that these problems stem from a number of sources.

The functionalist approach and the norms of positivism dominate management studies. Texts on qualitative methodologies (for example Berg, 1998; Marshall and Rossman, 1999; Rice and Ezzy, 1999) abound with advice on how to get approval for, and more importantly, seek funds for qualitative research in the face of such a research culture. The theme underpinning this advice is the notion that the dominant value system of the "scientific method" need to be convinced that qualitative methods are valid and that the use of such methods will not threaten the credibility of the academic institution or funding body. This is a powerful influence to couch the methodology of qualitative methods in such a way as to be acceptable to the majority positivist viewpoint. Research using grounded theory methodology may be compromised, not so much by the expertise of the researcher, but by the requirements, demands and expectations of the majority. It may be argued that the use of grounded theory in management research is a political issue, and that politics is defining grounded theory rather than the researcher.

There are, however, a number of methodological issues that have been identified that compromise the application of a "pure" version of grounded theory in organisational research. These concerns relate not only to the practicality of the research process but also to the conceptual issues.

Partington (2000) suggested that grounded theory is bewildering in its complexity. To illustrate, Orton (1997) identified 29 separate stages in the iterative grounded theory process when conducting organisational postmortems using library data. To researchers, especially those trained in the "scientific method", the magnitude, complexity and ambiguity of grounded theory is overwhelming, compelling researchers to either abandon the project totally or to simplify the process in order to make it more manageable. It is also possible that such researchers are not comfortable with the intensely personal nature of grounded theory research, requiring the researcher to directly engage in face-to-face conversations with respondents, often dealing with specific and emotionally charged issues. In addition, given the time and cost constraints that delimit most research endeavours, the

need to truncate such a long and involved process could be driven by practical concerns. Partington identified a pressing necessity for grounded theory methodology to be codified and simplified if it is to be used successfully in management studies.

Partington (2000) also argued that researchers are frustrated by the lack of consistency of approach in grounded theory, especially in organisational research, and the associated difficulty in replicating research or building on the research of others. Given the tradition of research in organisational studies, the cornerstone of which is just such approaches, this has probably further limited the appeal of grounded theory to management researchers.

Conceptual issues are also of concern. Orton (1997) argued that Glaser and Strauss's portrayal of the research as bipolar — with deductive, theory-testing, quantitative, normal science on one side and inductive, theory-discovering, qualitative, paradigm shifting on the other side — is "starting to fray around the edges" (p. 421). Tradition, however, insists that a researcher commit to one camp or the other, encouraging the distortion of data to fit the theory or the distortion of theory to fit the data. As Orton pointed out, there is some ambiguity within Glaser and Strauss (1967) around the question of whether theories are discovered — implying the existence of an objective world — or generated, implying the existence of a socially constructed world. Orton suggested that organisational researchers should seek some position between the two camps in a process that he calls iterative grounded theory, aimed at "zipping" the gap between process theory and process data. This, however, is likely to increase the complexity and ambiguity of the research process, making it even more inaccessible to many researchers. Orton does, however, make the point that grounded theory has evolved since the original Glaser and Strauss publication in 1967, making the definition of "pure" grounded theory even more elusive.

Sociological models have been applied to the understanding of organisations (see Burrell and Morgan, 1979). Nevertheless, the dynamics of business organisations and that of the wider society have important differences. The contrived nature of organisations and the notion of a created purpose — together with the impact of power and authority within the bounded environment of the organisation — create unique dynamics. It may be argued that grounded theory, developed within the discipline of sociology, does not recognise the

possibly different nature of the business organisation. The question remains whether or not the requirements of grounded theory methodology, designed for used by sociologists, can be met in studies of organisational behaviour.

Whiteley (2000) argued that there are constraints within the organisational environment that render the "pure" form of grounded theory unachievable. Organisations, as a consciously created social structure, have meaning inherent in their systems and processes. Organisational structures and processes inevitably compromise the notion of the negotiated role that is central to symbolic interactionism and, hence, grounded theory. (See the previous discussion.) Roles are created by the management of the organisation and are reflected in job titles associated with organisational structure diagrams, job descriptions and performance appraisal systems. In grounded theory, the core requirement is for theory to emerge from the data. Associated with this is the notion of suspended preconceived ideas. Whether this is achievable in the labeled environment of the organisation must be challenged.

Similarly, management processes also constrain how roles are enacted in organisations. Constraints on the enactment of roles may extend beyond the functions within the organisation and embrace legal requirements. For example, in the clinician manager role, part of the management role is determined by the requirements of the *Financial Administration and Audit Act (FAAA) 1985,* which specifically addresses accountability relationships between health service organisations and the Parliament. The clinical practice component of the role is determined by the Nurses Act 1992. For a research subject to reflect on their interactions within a role without considering imposed constraints is not feasible. Any theory generated from these reflections will be influenced by requirements for the role that extend beyond the interaction between the individual and those in the role set.

The lack of organisational research using grounded theory methodology may also relate to the inability to achieve "'pure" grounded theory in the organisational context. The ability to discover rather than force the data may present insurmountable problems in the contrived nature of modern organisations. This is not, however, cause to reject grounded theory.

Whiteley (2000) argues that the theory, as well as the symbolic interactionist perspective on which it was based, are important milestones in the development of interpretive thinking and research. Although "pure" grounded theory can and should be considered a benchmark, it should be recognised that "'pure" grounded theory conditions cannot be met in all circumstances. Whiteley suggests that grounded research be the descriptor for research conducted under such circumstances. This was the approach taken in this research.

4.4 The research design

The research took an approach to the qualitative research process that represented a synthesis of several writers in the area (Berg, 1998; Creswell, 1998; Marshall and Rossman, 1999; Rice and Ezzy, 1999) and is summarised in Figure 4.2.

The literature review was conducted to establish a need for the research and to identify possible theoretical approaches. The symbolic interactionist perspective, operationalised in terms of sensemaking, surfaced as the approach of choice and was the flexible analytic framework. Data was collected from a sample bounded by the context of the study and analysed for "fit" with the framework and then reinterpreted and presented in a way that best explained the findings.

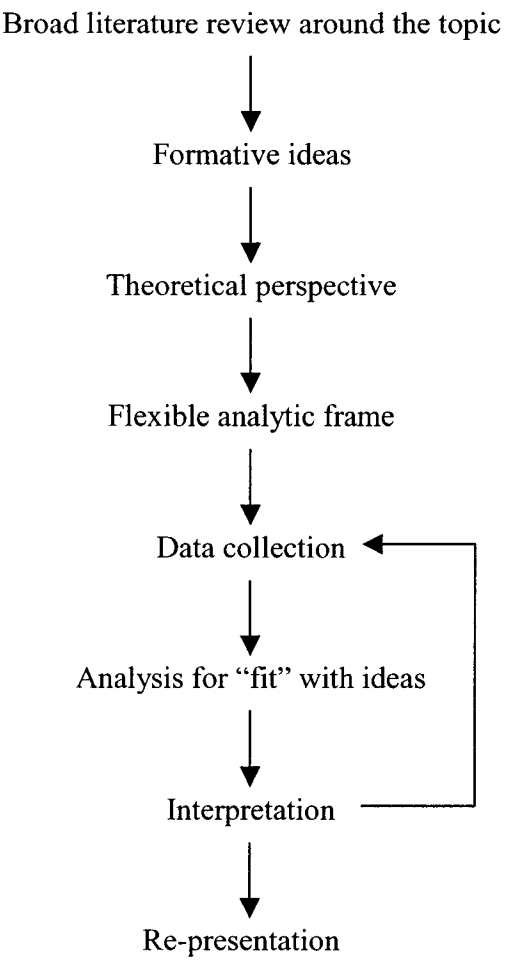

Figure 4.2: The qualitative research process

Grounded theory, a qualitative methodology, was used to frame the data collection and the analytical approach. The constraints in applying the "pure" form of grounded theory in this organisationally situated research was acknowledged and a grounded research approach, the application of grounded theory methodology constrained by the circumstance of the research, was used. Specific constraints that were encountered are identified in the relevant areas in this chapter and in Chapters 5 and 6.

The design of the research was adapted from that for naturalistic inquiry described by Guba and Lincoln (1988). Purposive sampling, inductive data analysis, grounded theory and the emergent design interacted in a cyclic and iterative way, driven by the data. Within this

process, there was continuous testing for the coherence of the explanations of the data. The research design is illustrated in Figure 4.3.

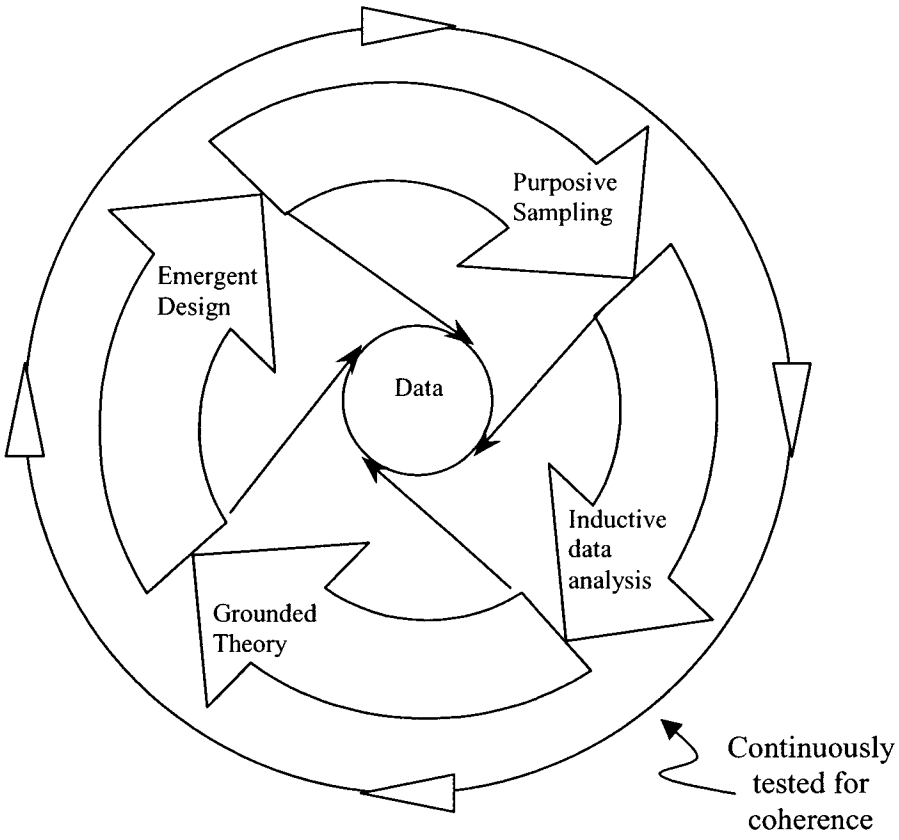

Figure 4.3: The research design

4.5 Research sample

The role of the clinician manager, in various guises, has been adopted in a number of health service organisations. The literature review supported the assumption that the experience of the role would be influenced by several environmental issues related to the clinical background of the person in the role, the reasons for the adoption of the role, and the size and type of health service in which the role was adopted.

Given the exploratory nature of the research and its symbolic interactionist framework, the nature of the research was considered to be contextual. The research sample was selected to

minimise variation and to maximise homogeneity in order to describe the role enactment process in as much depth and detail as possible. The sample was chosen more for its access to the phenomenon rather than its representativeness.

The selection of the sample became one of elimination. From all the examples of clinician managers in Western Australia, the sample was limited to one clinical group; namely, nurses and then to one context: health services. The research population then became DON/HSMs in rural health services in Western Australia. The sampling strategy can be best described as criterion sampling, where all cases meet some criterion (Creswell, 1998). The process of sample selection is illustrated in Figure 4.4.

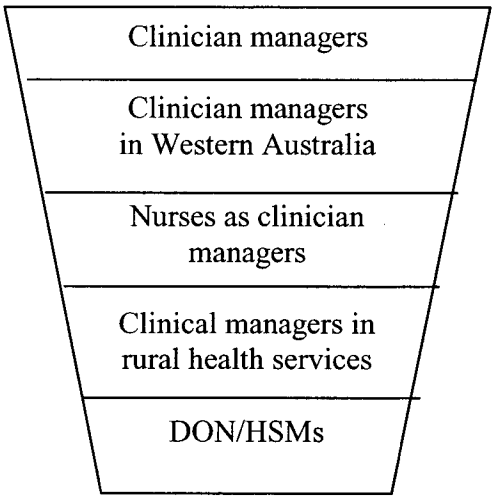

Figure 4.4: The process of sample selection

When this research began in August 2000 there were less than 50 rural hospitals in Western Australia that had a DON/HSM position. In order to choose respondents who could inform the research, those who were in "acting" positions and those who had been in the position for less than three months were not considered appropriate for the study because of their limited experience in the role.

The approach followed the process of theoretical sampling, an essential component of grounded theory in a delimited way. Theoretical sampling is sampling on the basis of concepts and have proven theoretical relevance to the evolving theory (Strauss and Corbin,

1990). Theoretical sampling requires the initial selection of a homogeneous sample and then, in the light of developing theory, pursuing further selected samples in order to confirm or refute the conditions, both contextual and intervening, under which the model holds (Creswell, 1998). In this case, because of the relatively small numbers that met the criterion for inclusion in the sample and the homogeneity of the sample, the second step could not be undertaken in the manner suggested by "pure" grounded theory. Access to a wider sample was not congruent with the aim of the research, which was not to describe a phenomenon, but to describe the experience of a clearly defined sample bounded by an organisational position. The difficulty encountered in operationalising theoretical sampling in this research illustrates one of the problems faced when using grounded theory methodology in the organisational context rather than the broader societal context.

In addition, as the aim of the research was to generate a substantive theory in one particular situational context, informants from another context could not clarify the theory-development process. Similarly it was not considered appropriate to seek the input of others in the same context who were not DON/HSMs. The aim of the research was to access the DON/HSMs' experience of their role, not to try to validate their experience with the understanding of others. To this end, the DON/HSMs in rural hospitals in Western Australia became both the source of the data and the means by which the emerging theory was substantiated.

4.6 Data collection

Data were gathered from semistructured, in-depth interviews.

4.6.1 Interviews as data gathering

Interviews played a central role in data collection in a grounded theory study (Creswell, 1998). In-depth interviews are considered an excellent way of discovering the subjective meaning and interpretations that people give to their experiences (Denzin and Lincoln, 1994). They allow social processes and negotiated interaction to be studied that could not be studied in any other way (Daly et al., 1997). Easterby-Smith et al (1991) suggested that unstructured or semistructured interviews are an appropriate method when it is necessary to understand the construct that the interviewee uses as a basis for opinions and beliefs about

a particular matter or situation, or when the step-by-step logic of the situation is unclear and/or the subject matter is highly confidential.

The purpose of the interview was to gather descriptions of the experiences of the respondents. The aim was to see the research topic from the perspective of the interviewee. The interviewing process may vary according the structure of the interview. Interviews may be very structured, with each respondent being asked the same predefined questions. Alternatively, a semistructured approach may be taken, indicating a number of set questions and a number of broadly based open-ended questions aimed at keeping the interview generally focused on the issues of concern. This was the approach taken in this research with the structured questions relating to demographic issues. The interviews were what Grbich (1999, p. 84) described as "guided conversations". The focus of the interview was the symbolic processes, actions, phases, rituals and stories that provided the unfamiliar circumstances of the new role with coherence and understanding. The interviews followed the pattern suggested by Glaser and Strauss (1967), with interviews at the beginning of the research consisting more of open-ended conversations. Later interviews were directed by the emerging theory and focused more on the identified categories.

4.6.2 The interviewer–interviewee relationship

The relationship between the interviewer and the interviewee during the interview process needed to be made clear before the interviewing process began.

Spradley (1979, p. 8) stated "If we want to find out what people know we must get inside their heads". This point of view raises two issues. First, it reflects attitudes that the interviewer holds about the nature of the respondent and their role in the research. The Spradley viewpoint seems to be supporting the notion of the passive interviewee who, if assessed in the right way, will pour forth all. Second, it raises the issue of how much should a researcher push to get beyond a superficial answer. To "get inside the heads" of the respondents and push respondents into areas of psychological discomfort in the name of obtaining "good" research data was viewed as unethical behaviour . The principle of "do no harm" appears to be appropriate and was adhered to during this research.

On the other hand, McMillan and Schumacher (1993, p. 266) wrote:

> To mitigate the disadvantages of interviewing, the interviewer should be thought of as a neutral medium through which information is exchanged. If this goal is attained, then the interviewer's presence will have no effect on the perceptions or answers of the respondent.

This viewpoint sees the interviewer as the passive presence in the interview process, a view not supported in this research While it was accepted that the interviewer should not dominate the interview relationship, the view was taken that the interviewer cannot be completely neutral. The interviewer's understanding of her own beliefs, needs and interests will influence the questions asked and the understanding of the answers. In the later interviews in this research particularly — when the researcher was attempting to substantiate emerging data — the interviews became more structured, and the interviewer participated more as it became necessary to explain developing theories before seeking opinions. The underlying philosophy about the interview process, however remained. This philosophy reflected the notion that the research interview is a reciprocal process conducted in an atmosphere of friendly collaboration. The opinions and experiences of the interviewees are valid, and it is the role of the interviewer to respond to the interviewees' understanding of the their experiences rather than the interviewer's opinion.

4.6.3 Access to the research sample

In June 2000, the research was explained at a DON/HSM meeting conducted in Perth and attended by most of the DON/HSMs in the state. At that time those who were willing to be interviewed for the research were asked to sign an agreement. All those present expressed a willingness to participate. The interviews were conducted over a six-month period in the second half of 2000. In all, 36 interviews were conducted, providing over 44 hours of recorded audio tape.

The interviews were conducted in the respondents' place of work. This required the researcher to drive some 8,000 kilometres to visit each rural health service. To conduct the interviews at the rural health service was considered to be important. It gave the researcher

a sense of place, which served as a prompt in the interviewing process. It was also considered that the respondents would feel more comfortable in their own environment.

Each respondent was approached by telephone to arrange an interview time. Because of the need for the researcher to travel long distances, the times for the interviews became less flexible than would have been desired. Coordinating interviews presented some logistical difficulties. The DON/HSMs, however, were extremely enthusiastic and cooperative, moving meetings, altering travel plans and generally making every effort to participate in the research. The respondents were asked for a two-hour time slot, a big demand in a busy day.

None of the DON/HSMs approached refused to be interviewed. A number of them said that nobody had ever asked them about their experience before and generally expressed amazement that their experience could be considered the subject of research. Several claimed that the experience of the interview was "therapeutic" and served as a "debriefing session".

4.6.4 The interview procedure

The tape-recorded interviews lasted between 60 and 90 minutes. The first 30 minutes of the interview time was spent establishing an understanding with the interviewee. Most of the respondents the researcher had met previously, either at the meeting in Perth or in other professional circumstances. Those that the researcher had not met, although eager to contribute to the research were somewhat wary, uncertain of the researcher and who would have access to the data. Time spent alleviating concerns and establishing rapport was well invested. In this time it became apparent that the researcher's knowledge of the area of inquiry was of particular importance. That the researcher was a Registered Nurse with a long involvement in health service management both as a practitioner and an educator established credibility and contributed significantly to the ease with which this rapport was established.

During this period of establishing a rapport, and then in the interview, the issue of language emerged as having an important impact on the research process. Nurses use a lot of professional jargon in their communication with each other. Abbreviations, acronyms, metaphors and terminology specific to health care in general or nursing in particular is a feature of nurses' conversations. It may also be argued that management has its own language, but personal experience suggests that it may not be as inaccessible to the "lay" person as is that of nursing. Nevertheless, it is probable that a DON/HSM would explain their experiences to another nurse in different terms that he or she would to a non-nurse. That the researcher was able to understand and use the language of nurses impacted on both the content and direction of the interviews. The researcher had a ready empathy with the respondents and had to be mindful of the need to preserve a sense of analytic composure and rigour. This does, however, offer an illustration of the subjective nature of qualitative research.

On the completion of the taped interview, dependent on time pressures, the researcher spent some time with the respondent, often touring the health service or sharing a meal. These times were important because the informal conversation often clarified or added to issues raised during the taped interview. In the hours spent driving to the next interview, the researcher tape-recorded reflections on these informal conversations, often identifying issues to be raised at the next interview.

The interviews always began with demographic questions. The reason for this was two fold. Respondents seemed more comfortable beginning with specific facts and then moving towards more abstract descriptions of their experience. Second, it became apparent early in the research that some demographic factors impacted on the experience of the respondents and in this way shaped the interview. This will be discussed fully in the Chapter 5.

The remainder of the interview was less structured. Initial interviews were guided by the properties of sensemaking described by Weick (2001) but later interview were guided by the analysis of previous interviews and emerging themes identified. Many of the questions and follow-up probes were adapted and generated as considered appropriate to the given

situation. Appropriate and relevant questions arose from interactions during the interview itself, consistent with the description of the unstandardised interview suggested by Berg (1998).

All interviews were audio taped for future analysis.

4.7 Data analysis

The interviews were transcribed verbatim from the audio tapes into Microsoft Word documents and then into Rich Text Format (RTF) files. This resulted in 772 pages and approximately 293,000 words of transcribed data. These data were managed using NVivo software, which assisted in the analysis of the data.

NVivo provides a range of tools for handling data records and information about them for browsing and enriching text, coding it visually or at categories and annotating and accessing data records (Richards, 1999).

As previously discussed, the research used a grounded research approach. The analysis of the data was shaped by the coding procedures as articulated by Strauss and Corbin (1990). Explanations will be offered when the prescriptions of this process were modified to meet the constraints of this research.

The first step was open coding, where initial categories of information about clinician managers' adaptation to their role were identified. These categories were assigned to nodes within NVivo and given names meaningful to the researcher. Memos were used to record initial impressions about the meaning of the categories. Data analysis began after the completion of the first six interviews. As other interviews were completed, they were added to the database. With each addition, the categories were revised, added to, merged, deleted and renamed as the understanding of the data changed. The coding therefore evolved, following the method of constant comparison (Glaser and Strauss, 1967).

As interviews tended to be done in blocks — with one to six interviews done in any one block, dependent upon road trips — the amount of recoding varied. The understanding of the data at any given time shaped the next block of interviews. In this way, the interviews

became more focused on specific areas of concern, and the emergence of new categories grew less. After 20 of the 36 interviews, no new data emerged regarding the categories, and the relationship between the categories was stable. This point is described as theoretical saturation (Glaser, 1992; Glaser and Strauss, 1967; Strauss and Corbin, 1990).

After this another sixteen interviews were conducted. The purpose of conducting these interviews was to substantiate the data. Due to constraints on theoretical sampling in the context of this research, the DON/HSMs in rural hospitals in Western Australia became both the source of the data and the means by which the emerging theory was substantiated. Conducting further interviews within the same sample was analogous to pursuing further selected samples in order to confirm or refute developing models. In addition, the interviews added to the richness of the description of the categories and contributed to the verification of the data, which is congruent with Creswell (1998) who suggested that prolonged engagement in the field adds to the trustworthiness of the data

Demographic data were also recorded. In NVivo demographic data are recorded as attributes and are related to specific interview data. These data were used in a number of ways and allowed the researcher to ask what respondents who matched particular attribute criteria said about a particular category coded in a named node.

At the completion of the interviews, and following the open coding process in which categories were identified by a constant comparison, 48 stable and coherently different categories emerged.

The open coding stage was followed by axial coding, a technique by which data are put back together after open coding by making connections between the categories. The Paradigm Model proposed by Strauss and Corbin (1990, p. 99) as structure for relating the categories proved difficult to apply in this instance. The paradigm model consisted of a systematised cause-and-effect schema that was used to explicate relationships between categories. The relationships are explained as follows:

Causal conditions → Phenomenon → Context → Intervening conditions → Action interaction strategies → Consequences

As the coding that created the categories emerged from the data, they did so in such a fashion that it made it difficult to match the emerged categories to the relationships prescribed by Strauss and Corbin. For example, this research was investigating a number of phenomena relating to one context, and that may have had several intervening conditions in common. It was considered that to recode the categories to fit the paradigm would compromise the sensitivity of the original coding.

Instead, using capabilities offered by NVivo, categories (coded at nodes) that were considered to explain a particular aspect of the clinician manager role were gathered together and placed in sets. The 48 categories were allocated to six sets. Case type nodes were also created that grouped nodes according to nominated attributes. Three case nodes emerged that were considered to be important to the analysis. Some categories (coded at nodes) were allocated to more that one set and to all case type nodes. Thus the reordering of the data was based on the ability of the sets to explain the phenomena. As this required grouping based on logical connections and on cases described by attributes, this provided a more reasoned explanation of the data. The sets will be discussed in detail in Chapter 7, when the emergent theory is explained.

The conditional matrix (proposed by Strauss and Corbin, 1990) was employed in a modified way. The conditional matrix is an analytical tool that represents a set of levels drawn as eight concentric circles. Each level corresponded to different aspects of the world, pertaining to the phenomena (p. 161). The approach recommended by the conditional matrix was used for the analysis of this data but in an applied way. First, it was applied to only one aspect of the data, specifically a set of categories (coded at nodes) of data relating to the role set of the clinician manager. The eleven nodes in this set were recoded, with three nodes being combined with other nodes that were thought to clearly identify seven separate components of the role set. These components were then arranged in a hierarchical manner as indicated by the conditional matrix. The labels appropriate to this research were assigned. The levels identified in this research were driven by organisational structures and

relationships, reflecting the organisational-behaviour focus framing the research. The conditional matrix, with its origins in sociology, has a broader focus, not directly applicable to this research. For example, to seek explanations at a national and international level, as suggested by the conditional matrix, appeared an unnecessary refinement. Such influences have been described in broad terms in Chapter 2.

The remaining sets and case node sets were re-examined and were considered to describe the data in the most logical and coherent way and best represent the experience of the DON/HSMs. These sets formed the basis of the narrative explaining the findings of the research and are presented in Chapters 5 and 6.

4.7.1 Theoretical sensitivity

The notion of theoretical sensitivity needs to be explored in order to explain the cognitive processes that created the categories of the open coding and then the reordering of the categories under the adapted axial-coding process and modified conditional matrix. These coding processes gave meaning to the data and reflected the conceptual ability of the researcher. Theoretical sensitivity refers to the personal quality of the researcher (Strauss and Corbin, 1990, p.41). These writers further suggest that sources of theoretical sensitivity include literature, professional experience and personal experience (p. 42). In this research, the literature was the source of the conceptual framework of symbolic interactionism and its application to organisational behaviour, sensemaking. Coding reflected these underpinnings. The professional experience of the researcher included practice as a Registered Nurse and experience in teaching health services management at a tertiary postgraduate level. Personal experience included living and working in rural areas. The researcher brought to the research knowledge and experience that heightened awareness of the subtleties within the meaning of the data.

4.8 Limitations

This study was contextual in nature. The justification for choosing a bounded study lay in the complex and complicated environment. Sufficient in-depth attention could be given to

enable a density of information and vividness of meaning that made it possible for the findings to be described in terms of patterns.

The research investigated the experience of a particular research population, nurses as clinician managers, and within a particular context: rural Western Australia. The results of the research are generalisable to other contexts in only a very limited way.

4.9 Ethical Issues

The proposal for this research was approved by the Research Ethics Committee at Curtin University of Technology.

Participation in the interviews was voluntary. Each participant was requested to sign a statement signifying their agreement to the voluntary nature of the interview, the data collection methods and their satisfaction with the provisions for confidentiality offered by the researcher. See Appendix 1.

All interviews were audio taped and transcribed verbatim. Identification numbers were allocated to the document files, but names of respondents or the health services were not included. Audio tapes will be destroyed upon the completion of the research. Verbatim transcripts will be retained electronically in the archives of the School of Public Health at Curtin University for a period of five years, in accordance with Graduate School of Management policy.

Data is reported in aggregate terms only. Direct quotations are not associated with an individual by name or place of employment, and respondents are not identified in any way in the narrative. Similarly, the names of the health services or the towns in which the health services are situated have not been included in this thesis because of the possibility of associating a particular individual with a named health service.

Chapter 5: Findings regarding structural elements

5.1 Introduction

This chapter will describe the findings drawn from analysing the text of the 36 interviews that were conducted in order to gather data for this research. The chapter will focus on the influences of stakeholders on the role of the DON/HSM.

Findings will be illustrated with quotes from the text of the interviews. In these quotes incomplete statements that do not have a clear meaning, automatic speech patterns and inappropriate adjectives have been deleted. This facilitates the reading of the quote but does not change the meaning. Place names and people's names have been deleted for reasons of confidentiality. Quotes from the text of interviews are italicised.

Although the sample chosen was homogeneous in that it accesses DON/HSMs in rural Western Australia, the analysis revealed three groups in the sample, each of which faced a different set of problems when adapting to the new role of clinician manager. This chapter will begin with a description of these groups and an explanation of the factors that impacted on their experience.

5.2 The three groups

The groups within the sample are described in terms of how they acquired the job of DON/HSM. The first of these groups consists of those individuals who were Directors of Nursing in the health service prior to the restructuring of the rural health services and the implementation of the DON/HSM role. They then moved into the DON/HSM role. Nine of the respondents (25% of the sample) fell into this category.

The second group consists of those individuals who had filled a clinical nursing role in the health service and have moved "up" to the DON/HSM position, usually some time after the

implementation of the role. Nine of the respondents (25% of the sample) fell into this category.

The third group consists of those who filled the position from outside the health service, applying for the job in response to advertisements. Eighteen of the respondents (50%) fell into this category. Due to a numbers of factors, each of these groups faced differing influences in their socialisation and the experience of adapting to and enacting the role.

5.2.1 From DON to DON/HSM (group 1)

These respondents had each been a Director of Nursing (DON) in the health service prior to the implementation of the DON/HSM role. The time they held the position of DON varied from a few months up to 20 years. As a DON, they had been responsible for the management of the nursing service of the hospital only and dealt with an FTE budget (full time equivalent nursing staff) rather than a dollar budget. Administrative duties and the management of the hotel services had been the responsibility of the administrator. Both the DON and the administrator reported to their respective superiors at the regional level. Over the years, the relationship between the administrator and the DON was variable, often characterised by conflict over control of and access to resources. As one respondent explained:

> *There were two of us running the place. I ran the nursing side...I was not given any touch on the finances whatsoever. And the administrator ran the financials and accounted for what I spent. And never the twain shall meet.*

With the implementation of the DON/HSM role, the administrator role was abolished and the DON was required to assume this role in addition to the DON role.

At the time of the interviews for this research, the respondents in this group had been in the position of DON/HSM the longest — an average of nearly five years. They had all been in the position since its inception in their health district, but as not all districts adopted the role at the same time, there was some variation in the time they occupied the position. The range was from four to six years. Although all were Registered Nurses, their educational experience was varied, with over half not having an undergraduate academic degree and

only two having postgraduate academic qualifications. Four of the nine had completed a Health Department of Western Australia (HDWA) sponsored, university-based diploma program that was put in place to meet the learning needs of those in the DON/HSM role. This program had been implemented some two years after the first DON/HSM positions were filled. All of the respondents in group 1 were female and aged in their forties or fifties. The average age was 47.

How the restructuring of the health service was managed impacted on the DON's adaptation to the new role. The degree of change that was inherent in the implementation of the DON/HSM role is characterised by one respondent who described the process in the health service like so:

> *...to create the DON/HSM role they abolished the administrator's position, the deputy administrator's position, the admin assistant position, the admin assistant hotel services, the DON and the deputy DON. There were six people, full time staff doing the job that one person was now expected to do — as well as do clinical.*

The implementation of the DON/HSM role did not just represent the reordering of two roles but was a major upheaval within the health service. Central to this upheaval was the role of the DON/HSM. The process of appointing the DON to that position appears to have been informal. The positions were not advertised, and the incumbent DON was expected to take over the new role with no increase in remuneration. The new DON/HSM role was officially a nursing position, with the incumbents continuing to be paid as Level 5 under the *Nurses' (ANF – WA Public Sector) Award 1994* [N0103].

When asked why they took a job that had a significant increase in workload and no increase in remuneration, the responses were similar. It was recognised that options were limited. To change jobs would mean to leave town and, for many different personal reasons, this was not an option. The other alternative would have been to assume a full-time clinical role. This also was not seen as an alternative. As one respondent explained:

> *I just kind of went with the flow. I didn't really have a great deal of choice. I didn't want to leave town, and I am getting too old for a full-time clinical job.*

It was apparent that a number of the respondents in this group took on the role reluctantly, motivated mainly by the need to remain employed in the town and maintain their current level of income. Others took on the role, however, with much more enthusiasm, seeing the role as offering a degree of control over the functioning of the health service that had previously eluded them.

The time frame for the implementation was very limited. Many described how there were required to assume the new position with only a few days notice. Lack of preparation in terms of education or a structured hand-over was identified as a problem for many respondents. Most described *working by the seat of our pants, like nurses tend to do.* The lack of preparation distressed some more than others, and this appeared to relate to the degree of confidence they had in their own ability to cope with the requirements to learn new skills and hence to do the job.

This confidence was influenced by the nature of the relationship with the administrator and the change-over process. The removal of the administrator was often difficult and happened in different ways. In some places, the administrator had already left, accepting an alternative position. Some had retired. In some situations, however, the departure of the administrator was quite a difficult and uncomfortable experience. Some administrators lost their jobs, requiring them to leave town in search of other employment. This created a great deal of animosity. There was anger directed towards the DON/HSM as many of the administrators believed that a nurse would be unable to do the administrator's job as well. The respondents reported the belief that many of the administrators felt that the DON/HSMs *had done them out of a job.*

The way in which the administrator departed had an important impact on the confidence and hence the adaptation of the former DON to the DON/HSM role. The largest learning curve for the new DON/HSMs was with the former administrator's component of the role; namely, managing the finances and managing the hotel services staff. If the DON and the administrator parted amicably, the new DON/HSM received a good hand over. Some were fortunate enough to get a very good grounding in the new aspects of their role. Others,

dealing with angry and bitter administrators, essentially had no hand over at all. One respondent in such a situation relates how... *I didn't even know what my budget was or how to get my monthly subsidy, which I had never heard of either.*

In summary, the DONs had little choice but to adopt the role of the DON/HSM. The implementation of the new role was not managed well, with the new job incumbents having very little idea of the nature or scope of their new role. Some of them embraced the new role as a challenge, seeing it as an opportunity to influence the delivery of the health service in a way they had never been able to do before. Most, however, acknowledge a fair degree of apprehension and freely admit, with hindsight, that they had no idea what they were letting themselves in for.

The steep learning curve aside, this group did have some advantages that the other groups did not have. They had an established credibility as clinical practitioners with the other nursing staff, the medical practitioners with admitting rights to the hospital and the community. Most were "locals" or had lived in the town for a long period. They were familiar with the town and understood its politics. They were recognised as having a leadership role by both the health service staff and the community, even if it was as the "Matron". They had established relationships with the medical practitioners in town and the hospital board (which may or may not have in place at that time). They also had an established network with other DONs in the same position and had some understanding of the political machinations that, in common with most government bureaucracies, is a feature of the Health Department of Western Australia (HDWA). They were also assuming the management of a health care service that they had had a significant role in shaping.

5.2.2 From Level 2 to DON/HSM (group 2)

These nurses had been working in the health service for varying periods of time, many of them on a part-time basis in a clinical role. Most had been Level 2 clinical nurses, but one had been a Level 1. They largely came into the position by default. Generally, they had a history of relieving the DON and later the DON/HSM during annual leave, sick leave and maternity leave. They were often the acting DON/HSM when the position was not filled. A

number were in health services that had a history of a high turnover in the DON/HSM position, with one health service having had five incumbents in the previous 18 months.

Eventually, after various periods of acting in DON/HSM position, these nurses, for varying reasons applied for the position. A number described how, when in the acting role, they started working with different programs and became reluctant to give these up. As one respondent said *I just became hooked, I think.* Others described how they were encouraged to apply for the position by the health service staff or the board or the General Manager. This encouragement was variously interpreted as pressure or support. Others took the job because they perceived that there was nobody else to take it, and they were very concerned about the future of the health service. Although motives for applying for the position vary, there was still the feeling there was an element of choice, a different situation than that experienced by Group 1.

At the time of the interviews for this research, the respondents in this group had been in the position for periods varying from two to five years, with an average of 3.4 years. While one person had been in the position since its inception in their health district, most had commenced their occupancy of the role after this. Generally, this group tended to be less educated than Group 1, with none of the group having a postgraduate academic education and only three having an academic undergraduate degree. All except one, however, had completed the HDWA university based diploma for DON/HSMs. In this group, all except one were female. The age range was 31 to 53 years, with an average of 43, making them slightly younger, on average, than those in group 1.

The experience of adaptation to their new role for those in this group had some quite different influences than did those in group 1. On the whole, they received no orientation or hand-over as it seemed to be generally assumed because that they had acted in the position, they knew as much about it as anybody. Most reported that one of their biggest surprises was finding "doing the job" and "acting in the job" to be quite different experiences. When acting in the job, they mostly had not received any type of hand-over then either, and many of them had stepped in during a time of crisis. They did the best job that they could, and

found staff were generally kind to them, grateful that somebody was doing the job. The real pressures of the job did not really begin until the appointment. Once they became official, previously suppressed conflicts and demands emerged. After a period in an acting position one respondent reported on her knowledge of the job like so:

> *I had an idea ... a very small idea of what the job entailed, but I had no idea of the spectrum of it. And I really had no idea what I would be expected to do.*

Those in this group often undertook the role with a relatively high level of confidence in their ability to do the job, encouraged by their success in the acting position. This self-confidence was eroded as the realities of the job became apparent and a number reported a feeling of helplessness as they tried to make sense of the demands of the role.

The learning demands for this group was similar to group 1 in that they had a very limited understanding of financial management or of the human resource management demands. The learning, however, extended beyond this and the need for an information network became readily apparent to most of them. When assuming the position, most had an information network that would be expected of a Level 2 clinical nurse and generally did not extend beyond the health service. The need to establish information sources, especially in the HDWA, on a range of issues ranging from human resources, legal issues, financial issues and technical issues had to become a first priority. This proved to be a complex and difficult task. As one respondent said:

> *About three years down the track I can only honestly say that I'm just getting there, and working out what fits in where.*

Another surprise that this group encountered was the impact the role had on their personal life. Previous to assuming the DON/HSM role, these nurses had been part of the group that could be described as the "workers". This group was not only a work group, but also a group that spent social time together. With the new role, the dynamics of this group changed considerably. Confusion in work and social relationships was a feature of the first few months in the role, as explained by one respondent:

I had some problems in the first few months, because I was a bit unclear about how I did this. But I realised very quickly that I could no longer attend all the social functions and be one of them. I couldn't be a friend to everybody.

This experience is not isolated to the transition period, but created permanent changes in personal relations. There was the need to establish a new social life, which is often not easy given the small population of a rural community. In addition, there were changes in valuable friendships, something that was often regretted. On the other hand, it was also recognised that one could not go back. As reported by one respondent:

I'm not the person that they used to see me as because I've got other agendas and other goals and I've moved on.

This group had a number of issues to deal with in their adaptation to the DON/HSM role. Most did not aspire to the role but acquired it by default. The complexity and demands of the role they experienced as the incumbents — rather those experienced while acting in the role — was the first difficulty they faced. The next hurdle was learning the skills required for the new job. These skills generally related to financial management and human resource management, but the respondents also identified the need to acquire computing skills, writing skills and public-speaking skills as imperatives that they had not expected.

One of the biggest difficulty a number of them faced was the assumption of the leadership role and the subsequent change in their social lives when they found that their social group was no longer appropriate. It also meant, as time went on, that their options were reduced as returning to their clinical nursing role and their former working and social relationships would be very difficult. Most of these DON/HSMs were locals, having their family roots in the town. To leave their job would mean having to leave the town, which was not an option. It was pointed out by a number of respondents, they were probably encouraged to take the position because they were locals, as this was considered one way to address the high turnover problem because they couldn't leave.

Nevertheless, this group did have some advantages. They had established credibility as clinical practitioners. Most were locals or had lived in the town for a long period. They

were familiar with the town and understood its politics. They had to work hard, however, to establish themselves in the leadership role, both internally and externally. In order to do this, they not only had to establish working relationships with the staff of the health service, but they also had to extend their activities beyond the health service and establish networking relationships in the community and the health service in general. The workings of the HDWA were mostly considered to be a mystery. Having to look beyond clinical practice to the strategic direction of the health service was one of the biggest challenges, and as one respondent put it, this change in focus tended *to scramble my brain in the first instance.*

5.2.3 From elsewhere to DON/HSM (group 3)

This was the largest group and the most diverse. The group was characterised by their choice to take the position of DON/HSM. Most responded to an advertised position and went through a selection process. Their reasons for applying for the position in the first instance were varied, but most explained it in terms of needing a change of job or seeking a lifestyle change. Some 72% of these respondents had come from various positions in metropolitan hospitals, and the position of DON/HSM was their first experience in managing a health service in a rural area and, in a number of cases, their first experience in management. Of the remaining 28%, three had come from other positions within the rural health service in Western Australia, and two had come from similar rural DON/HSM positions in other states. As a group, however, this group faced some issues in the adaptation to the role with which those in groups 1 and 2 did not have to contend.

At the time of the interviews for this research, the respondents in this group had been in the position for period varying from three months to four years with an average of just under two years. Generally, this group tended to be better educated than the other two groups with over half having postgraduate academic qualifications. Less than half, however, had completed the HDWA university based diploma for DON/HSMs. In this group, seven (39%) were male. The age range was 32 to 57 with an average of 44, making them much the same age as group 2.

Those in groups 1 and 2 were, on the whole, "locals". Those in this group were all nonlocals or newcomers. This was an important consideration in their new role. What it means to be a local in a rural community is best explained by one of the respondents:

> *If you don't understand what it is to be a newcomer then you haven't got a hope of succeeding because the community will not trust you or accept that you are able to do it. They do allow newcomers a certain amount of time, but from experience I've learnt that for anybody whose coming from the metro area into a rural area and is coming in new it's probably ten times more difficult for them to be accepted, and acceptance is a very big issue.*

> *When I actually got the position, one of the board members came to congratulate me afterwards and said isn't it wonderful that we've been able to employ a foreigner. That's although I had lived at that stage only twenty minutes north of here for fifteen years, but they came from a family who probably can go back two hundred years here...and they felt that I was a newcomer and I always would be. My children are accepted as being locals. My daughter, certainly, because she was born in this area. My son still fights a little bit because he was about eighteen months old when we first came here.*

To live and work successfully in a rural community, one needs to understand the significance of being a nonlocal and how it impacts on the way in which a job can be done. The degree of awareness of this distinction was mixed in this group. Those that had a rural background or had worked in a rural area previously had an understanding of the issues. Those who had not worked in a rural area before, especially those from overseas, found the notion surprising and difficult.

Apart from being nonlocals, on taking up their new role those in this group faced a number of issues. Often they took over health services that had been in turmoil for some time. There was often a history of high turnover rates in the DON/HSM position, and they frequently found that the previous DON/HSM had left weeks ago and that the health service was being managed by a Level 1 nurse, the administrative assistant or — in one case — the receptionist. There was seldom a hand-over or an orientation program, although in some places the board adopted this role. The reception that the newcomer received was variable, but most report various levels of antagonism. A number reported being perceived as *the smart arse from the big city that's not going to last five minutes.* Most recognised,

however, that this antagonism was not without cause and reflected a history of regrettable management. In health services where there had been a high level of turnover in the DON/HSM position, many reported that *people had been very badly treated* and that *everybody was upset.*

A number of this group faced their first management experience in most difficult circumstances. The hospital staff were antagonistic, the rural environment strange and their understanding of the job that they were required to do was very limited. In addition, there were few role models — or indeed anybody —to turn to for advice. The experience was described like so:

> *When I got here I sat in my office and I thought 'Well what do I do now?' ... I was just waiting for the phone to ring... no staff came to talk to me. Looking back on it now I was so naive... some of the staff had particular demands and they were demanding things of me that I had no idea if I could do it or not...I'd get messages from outside departments wanting things, and I wouldn't know where they were or what they wanted or why they're asking for that sort of thing. I felt that I was so isolated.*

The first task that those in this group had to achieve was to establish their credibility with the staff. In many cases, this proved extremely difficult as the credibility had to be in both the management and the clinical areas. While most struggled with the management side of the job, the converse also happened. One respondent who had been a Level 3 Nurse Manager in the metropolitan area found little difficulty in the management requirements. Her clinical skills, however, were not as good as the staff would have liked. She found her lack of credibility in this area to be a huge hurdle.

One of the biggest challenges that this group had to come to terms with was the complexity of the role. A reflection of this complexity and the frustration it creates for those unprepared for it, is described by one respondent:

> *... this is the hardest job I've ever had. And you look at it. It's a little tin-pot hospital. It doesn't do a lot other than A and E, but there are no resources. You're it. I had to cook on the weekend ... I've been a gardener. I'm a clinician ... I do the x-rays ... I manage the place. You're everything to everybody, and there are just not enough hours in the day to do it.*

Although many of those in this group took the position because they were seeking a lifestyle change, the difficulty in establishing the new lifestyle was a surprise. Half of this group were single and had no family in town or established friendships to fall back on. Establishing social relationships with the staff of the health service was considered inappropriate, and there was a general feeling that *if you become too friendly with the community they take advantage of you.* It was recognised that it is *hard to get a life outside work.* The isolation of the role, both professionally and socially, was one of the biggest surprises for this group.

Despite the isolation of the role, another of the surprises for those in this group without previous rural experience was the relationship between the DON/HSM and the community. In rural areas, the DON/HSM is a public figure in a way that does not happen in the metropolitan area. Many found it very stressful to acquire a high degree of visibility after being used to anonymity outside working hours. As one respondent explained:

> *Whether you like it or not, you are suddenly a public figure. They watch how you behave, how you dress, what you say, how much you eat and drink, what car you drive.*

There was the feeling of being the property of the community on a 24-hour basis. Some viewed this with humour, but on the whole, the response was one of frustration and indignation.

As many in this group saw the position as DON/HSM as a career move, they were determined to make a difference. Most began the job with confidence in their ability to change what they saw as *entrenched patterns* and introduce innovations such as standards of care, evidence-based practice, infection control and quality assurance. The implementation of change often became a battle of attrition. The staff resisted because they thought if they held on long enough this nonlocal would leave like their predecessors, and the status quo would remain. The frustration for the DON/HSM was enormous, and all the respondents had stories of others that had indeed given up and left. This, in turn, reinforced the status quo, making it even more difficult for the next DON/HSM to change practice.

The respondents in this group faced a number of issues. Unlike the previous two groups they had not been exposed to any part of the role previously; they often faced antagonism in the role and had to also cope with the surprises of the rural environment. This was combined with their need to succeed in the role and this success was inexorably intertwined with their desire to succeed in their lifestyle change. The two respondents who had held similar DON/HSM positions in other states clearly adapted to this situation better than the others did. Their main learning requirements were in the reporting systems used by the HDWA and the necessity to build an information network. The three respondents who had previous rural experience were unsurprised by the idiosyncrasies of rural communities. Their main challenge was adapting to the their new operating environment and the requirements of management. To the majority group — those new to management in rural health services and unused to the expectations of rural nursing practice — the demands of the role were enormous. They were required to create a role, with little guidance, in an environment with which they were not familiar, drawing on a knowledge base in both clinical practice and health service management that most acknowledge they did not have to the degree that was required by the job.

The comparison between the three groups on a number of dimensions is summarised in Table 5.1.

Table 5.1: A comparison between the three DON/HSM groups

	Group 1	Group 2	Group 3
Previous management experience	Low	Very low	Variable, mainly low
Previous leadership experience	High	Low	Variable, mainly high
Previous clinical experience	High	High	Variable, mainly high
Knowledge of the local health service	High	High	Low
Knowledge of the Western Australian rural health care system	High	Low	Variable, mainly low
Knowledge of the local community	High	High	Low
Experience in rural areas	High	High	Variable, mainly low
"Locals"	Yes	Yes	No
Change in lifestyle cased by the job	Low	Moderate	High
Beginning understanding of the job	Low	Low	Low
Beginning self confidence in ability to do the job	Low to high	Moderate to high	High
Motivated to do the job by ...	Lack of suitable alternatives	Encouragement or pressure from others	Desire for lifestyle and/or career change

The issues that each of these groups had to face, although different in a number of ways, were also quite similar. All members of these groups were required to take on the responsibilities of the DON/HSM role. Because there was little precedent for the role, each had an influence in shaping the role and their own identity in that role. In order to further understand this process, and in concurrence with a sensemaking perspective, the data analysis turned to examining the conduct of others associated with the role: the stakeholders.

5.3 Stakeholders and the conditional matrix

Organisational role theorists (for example Katz and Kahn, 1978) prefer the term "role set" when describing the relationships between the role partners in a particular position. This research, however, takes the view that the notion of stakeholders describes the nature of the relationship more accurately. Stakeholders are those individuals and groups who rely upon the organisation for the achievement of their goals but who, in turn, the organisation relies upon for their support or cooperation (Blair and Whitehead, 1988). It is the influence of these stakeholders upon the role of the DON/HSM, as manager of the organisation, which is central to this research. As an analytic aid, a modified version of the conditional matrix proposed by Strauss and Corbin (1990, p. 158) was used. (See Figure 5.1)

The identity of the main stakeholders emerged from the interviews, as did the DON/HSMs' perceptions of the relative impact of these stakeholders. The conditional matrix reflects the collective views of the DON/HSMs interviewed for this research. As pointed out in the previous chapter, this conditional matrix reflects the organisational structure more than the hierarchical view of society suggested by Strauss and Corbin. This could best be viewed as a modified application of the conditional matrix, and for this reason has been depicted in rectangles rather than the circles that Strauss and Corbin employed. Nevertheless, each level represents a context in which action and interaction takes place — all of which has a bearing on the enactment of the DON/HSM role.

Central to the matrix is the role of the DON/HSM. Their first level of concern is the patients: consumers of the services of the health service. The next level of stakeholders is the staff of the health service: nurses and other staff. The board, as the employer of the DON/HSM and the body that is expected to provide the strategic direction for the health service, is the next level of stakeholder. The general practitioner (GP) who has admitting rights to the health service is seen as the next level, followed by the community in which the health service resides. The General Manager (GM), who has a dotted-line relationship with the DON/HSM is next, followed by the Health Department of Western Australia as the funder of health service. The nature of the stakeholding relationships between the role

of the DON/HSM and the levels of the conditional matrix is explained in the following discussion.

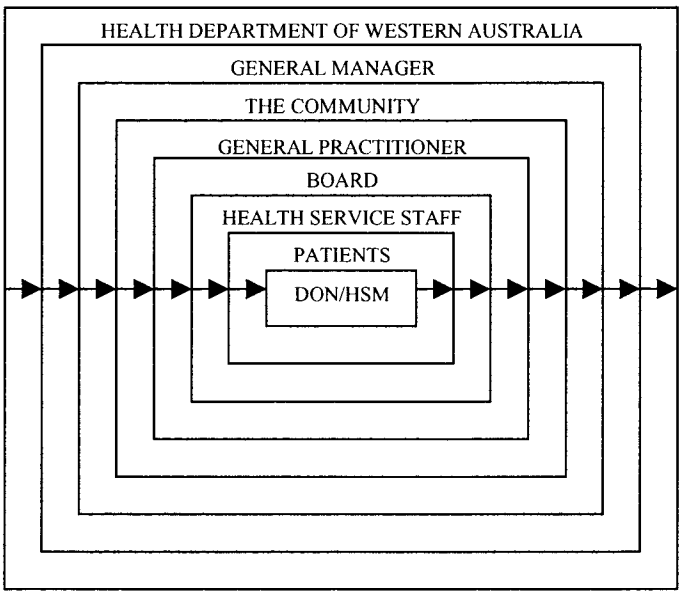

Figure 5.1: Stakeholders' conditional matrix

5.3.1 Patients

It was clear that the patients were core to the role of the DON/HSM and were their first priority under most circumstances. Most saw that *my duty is towards the patients in the community and to provide a service, and the rest is really, you know, other stuff.* It may also be argued that the need to provide patient care is the "glue" that holds the relationships of the stakeholders together and provides a focus to their activities; nevertheless, a number of respondents observed that, in the light of the varying and often conflicting demands of the different stakeholders, maintaining a focus on patient care was not always easy. It required *a bit of railroading* and *selective deafness* and *some major disagreements.*

All the DON/HSMs interviewed for this research firmly held the opinion that their role included patient advocacy, defending the rights of the patient and ensuring that the patient received the best possible care. In their view, the DON/HSM role, embracing both clinical and resource allocation decisions ideally placed them for just such a role and, as such, should be vigorously defended.

Even so, the interviews reflected a recent change in the nature of the relationship between the patient and the health service — further influencing the DON/HSM. Once, patients, especially those in rural areas, were grateful for any health care that they received. Lately, there has been a growth in consumerism with patients much more likely to complain about the health service, both directly and indirectly, via the media. The quality of care provided by the health service has become an item on the political agenda both at a local and state level. This makes the role of the DON/HSM more demanding, and as one respondent pointed out:

> *...although we encourage feedback, it is still not easy to come to terms with it, especially when you thought you were doing a good job.*

Recent times have also seen a change in the type of patients seen. Most respondents reported a dramatic increase in psychiatric patients and expressed concern about the lack of preparation of nursing staff to cope with the unique problems these patients presented. Some DON/HSMs reported that staff were leaving because of their lack of preparedness to cope with such patients. Similarly, the structure of the buildings was inappropriate for offering such care, which lead to expensive capital works decisions.

There was, however, an element of patient care in rural areas that makes it different from patient care in the metropolitan area in an important way. Often in rural communities, the local health service is the largest single employer. The patient population then takes on a more personal aspect because most patients are usually known to or even related to somebody working in the health service. Each DON/HSM interviewed for this research had stories such the serious road trauma who was an orderly at the hospital, the drowning who was the grandchild of the cook or the suicide who was a son of one of the nurses on duty. When the DON/HSM says that their priority is patient care, the patients they are talking about are often know to them (or other health service staff) personally. This adds an important dimension to the role and will be discussed further in the next chapter.

The DON/HSM was also required to make important decisions about patient care, especially in towns that did not have a general practitioner (GP) or when the GP was unavailable. When there is not a GP in town, many more patients present at the hospital,

and admission decisions are made by the nursing staff. Whether or not to evacuate the patient remains a critical decision, and the responsibility lies with the DON/HSM. Such decisions have care implications and also financial implications for both the patient and the health service.

Patient care was seen by all respondents as the core of the role and the first priority. As one respondent said: *the patients are the reason that I go to work.* The influence the patient exerts on role of the DON/HSM is summarised in Figure 5.2.

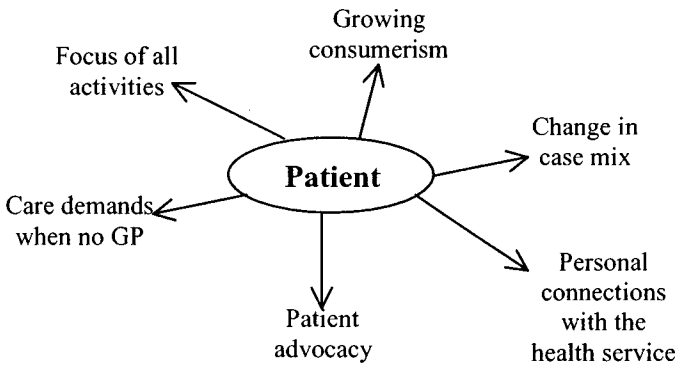

Figure 5.2: Patient influence on the role of the DON/HSM

5.3.2 Health service staff

The health service staff represent a complex issue. The DON/HSM role includes not only the line management of the nursing staff in the hospital but also those in community nursing services. It addition, there are the support staff that include the administrative staff and the hotel staff; e.g. cleaners and kitchen staff. If the health services had become a MultiPurpose Service (MPS) site, the DON/HSM was also responsible for the line management of the hostel staff and the staff of the Home and Community Care service (HACC) — often across several sites.

In many rural communities, the local health service is the largest employer in town and as such contributes significantly to the local economy. Many health services will employ a number of individuals from the same local family. Human resource management has become a very large component of the DON/HSM role and embraces a number of

industrial awards. The change of responsibilities inherent in the DON/HSM role meant that many of the respondents had needed to negotiate the content of the role with staff used to the previous organisational structure.

There was the general sense that different sections of the staff have different expectations of the DON/HSM. One respondent pointed out that *the staff doesn't take to this whole DON/HSM thing at all.* She went on to explain that staff see the DON or the HSM components of the role according to their problem. Nursing staff see the DON about clinical decisions and the HSM regarding resource allocations decisions, compartmentalising the decisions despite the fact they are the responsibility of the same person. That the nursing staff, in particular, want the DON/HSM to maintain the old "Matron role" was identified by a number of respondents. One explained:

> *Half want me to be a mother and look after them and know who everybody is and know about their mothers and their fathers and their ... who's dying and who's not dying and their kids and their ... They want me to know all that, but I haven't got the time to do it any more. I don't know them like I used to know them.*

That the staff, in general, do not understand the demands of the DON/HSM role was a recurrent theme. A typical comment was *I don't think any of the staff have a clear understanding of what my job is. They don't understand the demands of the management component, which I find very difficult.*

A number of group 1 and group 2 respondents identified the problems that the change of responsibilities from that of a purely clinical role to one that also entails management responsibilities. In the new role they are required to make resource allocation decisions that often see them at odds with the staff. One group 1 respondent reported that *they don't think I stick up for them nearly enough now.* As a number or respondents pointed out, it is not until *you get to the admin you realise that you can't have everything that opens and shuts. If there's no money in there to pay for it then you can't do it. And clinical people find that hard to accept.*

To be seen by the staff as credible in the DON/HSM position was conveyed by many of the respondents as being central to their relationship with the staff. This credibility must be established in both the clinical and management component of the job. A number of respondents offered stories of how other DON/HSMs, with perceived weaknesses in either component of the role lost credibility that, in turn, destroyed trust and morale. Credibility was also seen as a crucial element in the leadership role that all staff expected the DON/HSM to assume. The expectations the staff have of the DON/HSM is summarised by one respondent:

> *They want a leader who comes in, who mucks in, does whatever has to be done whenever it has to be done and, basically, looks after their interests as well — in terms of their rostering and their annual leave and all of their family problems and family commitments going on around them.*

Human resource management is a large component of the DON/HSM role. The wide range of staff, working under different industrial awards and with differing needs expect the DON/HSM to meet those particular needs. The impossibility of being all things to all people despite all efforts and the best of intentions was another recurrent theme in the interviews with the respondents. The necessity for the DON/HSM to negotiate the content of their role with their staff was apparent and problematic for DON/HSMs across all groups.

Those in group1 and group 2 had had to negotiate a new role within the same health service, which required a change of attitudes and understanding among many who preferred the old order of things. The staff that had previously reported to the administrator, most particularly hotel staff, often resented having to report to a nurse and often a female one at that. Some group 1 respondents reported disruptive behaviour and a difficult "settling in" period. Group 3 had to establish their credibility and establish their role, often in the face of either overt hostility and/or very high expectations.

There is another dimension to the relationship between the DON/HSM and the staff, particularly the nursing staff. At the time of writing, Western Australia was experiencing a shortage of nurses, and this shortage is more acute in rural areas, particularly in areas the

are considered, for what ever reason, to be unattractive. The most stable component of the nursing staff has often worked in the health service for many years and are locals. Of these, few work full time, some working only one day a fortnight.

The other component of the staff, usually nonlocals, generally has a high turnover, with most staying less that two years. Many are on contracts of only a few weeks. This situation has a number of consequences for the DON/HSM. A considerable amount of time is spent trying to find staff and negotiate with various agencies that provide nursing staff on a casual basis. In some health services, over 50% of the staff are from nursing agencies and are working on a shift-by-shift basis. A considerable amount of time is also spent trying to encourage present staff to work extra hours. When all else fails, the DON/HSM has to work shifts on the ward. Interviews for this research were conducted with DON/HSMs who were in just such a position.

The main problem, however, is that these issues combine to create an unstable workforce that, in turn, makes the implementation of any change of practice all the more difficult. As pointed out by one respondent

> *...we've probably got sixty per cent of the staff that is keen to get on and do new things. The rest come to work to do a job, to go home with a pay packet, and don't want anything new in their life.*

The nursing shortage also places the DON/HSM in a vulnerable situation. They find that they may have to employ staff that, given an option, they would have preferred not to. Staff also have a strong bargaining tool. A number of respondents reported times when they had to literally beg staff to work and were required to make concessions that, in other circumstances, would not have been made.

The role of the DON/HSM is a dynamic one with constantly shifting demands that are dependent on numbers and the skill mix of the staff that are available. The influences that the health service staff exert on role of the DON/HSM are summarised in Figure 5.3.

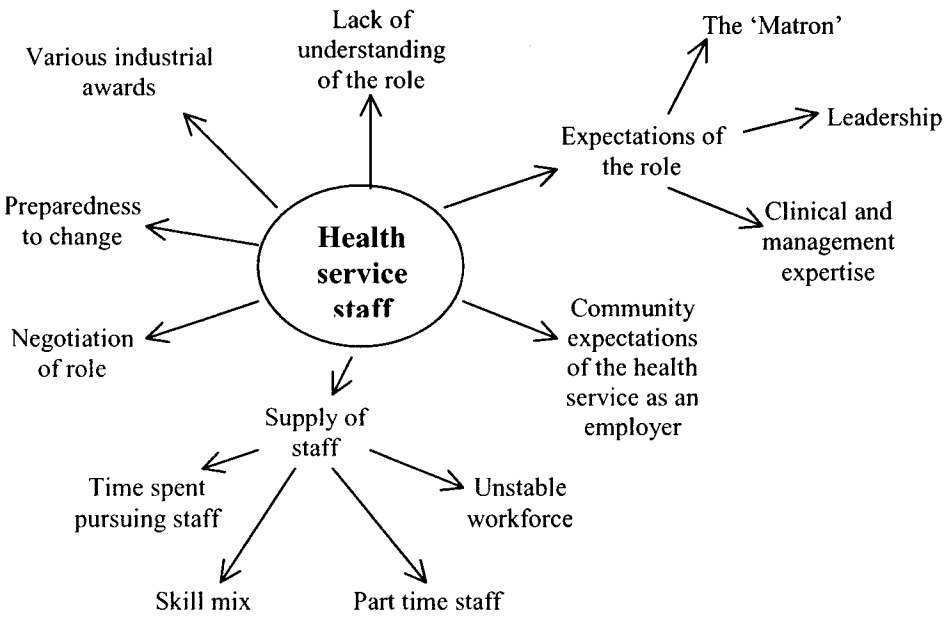

Figure 5.3: Health service staff influences on the role of the DON/HSM

5.3.3 The hospital board

From the respondents' point of view, the influence of the hospital board was variable. The development and change of function of hospital boards is discussed in Chapter 2. Under the restructuring of the rural health services, the health service boards became a statutory authority that governed the operation of the health service (and, as such, became the employer of the DON/HSM) and were responsible for strategic direction. Some boards were well established, having been in place for many years. Other boards, however, were formed in a response to the restructuring requirements. Since 1997, in some districts, hospital boards have amalgamated, creating district boards. In other districts, the boards have vigorously defended their independence and have resisted the formation of district boards.

A challenge for some DON/HSMs was working with a long established board that had a long tradition and firmly held beliefs about the relationship between the board and the health service or with new boards that had much less clear ideas about their role and function. Several of the respondents, especially those in group 1, reported that:

...although I was employed by the board, my role really was teaching the board what their role was.

Most board members were private business people with little experience with a government bureaucracy such as the HDWA or how the health system works. Educating the board became a time consuming component of the DON/HSM role. Rather than receiving support from the boards, a number of respondents found the roles to be reversed. As one respondent put it *the board essentially looks to me to solve most of their problems.*

A number of respondents also questioned the motives of some board members, suggesting that some are more interested in the community status associated with board membership than they are with learning requirements and the other work involved in the appointment.

In some situations, however, the board took a valuable role as the managing authority of the health services and the relationship between the board and the DON/HSM became an important partnership. Instances were reported where the health service was facing serious problems in terms of financial difficulties, relationships with general practitioners and outsourcing of services, and the positive relationship between the DON/HSM and the board had proved to be very important.

On the other hand, the board has created a number of problems for some DON/HSMs — particularly older boards who believed their role included the operational management of the health service. A number of DON/HSMs related stories of the Chairperson of the board being at the hospital on a daily basis, opening mail and giving instructions on everything from the delivery of health services to the planting of the garden. In addition, the perception was that the board would have preferred to see the DON/HSM *prancing about in a white dress with a veil.* Several DON/HSMs reported periods of conflict as they were required to negotiate their role. Again the degrees of conflict was variable, with one respondent reporting that the board had *caused me more grief in twenty-five years in health than any other situation that I have ever been in.*

Some DON/HSMs also inherited past conflicts with boards. With health services that have had boards for many years, there was often a history of critical events, some of which had assumed the dimensions of folk lore. These events tend to live on in the memories of the nurses that were there at the time as well as the community. These events are often remembers and the behaviour of the current DON/HSM evaluated in terms of what happened in previous times.

Most of the respondents, however, questioned the role of the board. One respondent summed up the general feeling by saying:

> *Why are you asking farmers and shopkeepers to make decisions about health and allocation of resources when they have no idea?*

It was most cases agreed that a lack of knowledge of health care was a characteristic of most boards. This led to *some fairly odd ideas about how the health service should look.* Persuading boards to adopt a different perspective was a time consuming and frustrating process. The difficulty in negotiating such a relationship with one's employer was also identified.

The DON/HSM, on the other hand, can influence the board considerably. The DON/HSMs in group 1 and, to a certain extent, in group 2 have a significant advantage here, being aware of local politics. One respondent related how:

> *... I knock on people's doors and encourage them to join. The right people of course. None of my enemies. Most of them we have saved their lives or saved their kids' lives or delivered their babies or done something for them.*

This ability to influence the board membership was identified by a number of other respondents.

Most of the respondents saw the role of the board in similar terms. The board should have no operational involvement and should involve themselves in strategic issues only. The general feeling was *they pay me to manage the hospital and that's all there is.*
The boundaries of the relationship between the DON/HSM and the board is negotiated over time, the process being summarised by a group 3 respondent:

When I first there was a period of testing ... They didn't push me all that much at all. Then it gently started ... "We want this" and "We want that"... if it was reasonable I didn't mind giving it to them. But if it's unreasonable ... when it came to clinical decisions and care, forget it. I run the hospital. I'm the one with clinical expertise.

The relationship between the DON/HSM and the hospital board is complex, often influenced by personal conflicts and local conditions. The broad influence the health service board exerts on role of the DON/HSM is summarised in Figure 5.4.

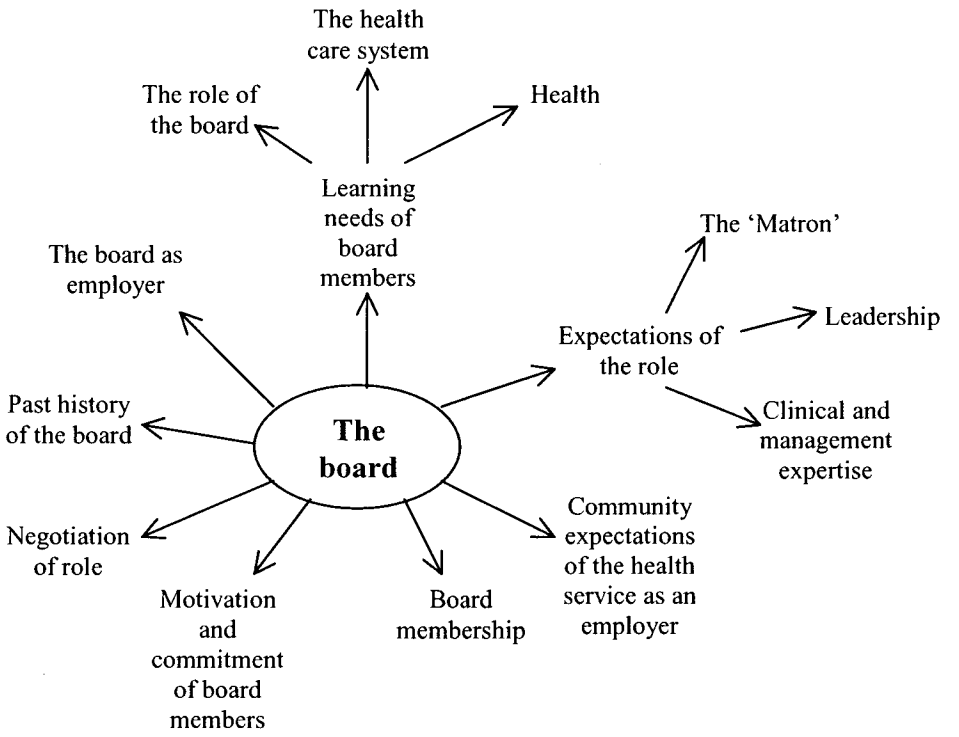

Figure 5.4: Health service board influences on the role of the DON/HSM

5.3.4 The general practitioner (GP)

The general practitioner (GP) has a very important influence on how the DON/HSM can do their job. All the DON/HSMs interviewed for this research worked in health services where the medical practitioner was not an employee of the health service. All the GPs were in private practice and had admitting rights to the hospital under a contractual agreement with the hospital board. In this way, the GP controlled who was admitted to hospital and the

treatment they received. It also placed the DON/HSM in the precarious position of being legally accountable for the clinical services provided by the health service while having very little control over the practice of the GP. It also meant that medical practice had a considerable impact on the consumption of resources and, hence, the budget. Thus the DON/HSM has a very tenuous control over the costs in a budget for which they have legal responsibility. On the other hand, because the GPs worked on a fee-for-service basis, the management of the health service could also impact significantly on their personal income. The possibilities for a relationship fraught with conflict are endless. One respondent explains the situation:

> *But in the way that they can influence our practice, we can influence their practice. And by influencing their practice we can influence their income. And that is a big problem. But they also influence our income. By controlling which patients they see, what treatments these patients have and who will be admitted to the hospital, their practice influences our budget enormously. And we do not have very much control over doctor's practice. That is the most important thing you have in trying to control the budget. And especially private practitioners, which is a problem that all country hospitals have with their GPs. They call the shots.*

> *If they want to set up a new service you can stop that if there is not money. But if they want to use a medication that is $300 per dose on a patient, it is incredibly difficult to argue with them. And if they say that these patients are emergency and will have to have surgery in the evening when we have to call in staff and pay them overtime, there is largely nothing we can do about it. We try to negotiate but it is extremely difficult. They do not like being influenced by a nurse and certainly don't think that nurses should be able to tell them what to do.*

The implementation of the DON/HSM has changed the GPs relationship with the health service. Previously, their clinical practice was in collaboration with the DON who had little concern with the financial impact of such practice. The administrator, responsible for the health service budget did not have a clinical background and did not have the knowledge or ability to influence clinical practice Many GPs, especially those who have been in town for a long period of time *have treated the hospital like their own private hospital.* The DON/HSM with a clinical background (albeit not in medicine) as well as responsibility for the management of the budget is in a unique position to make decisions regarding the balance between clinical practice requirements and budgetary constraints. This scope for

informed decision making is one of the drivers for the implementation of the clinician manager role. It does, however, represent a significant change to the practice of the rural GP *and they certainly do not appreciate a nurse saying no to them.* There are a number of issues that impact on such decision making and, hence, the role of the DON/HSM. As one respondent pointed out:

> *Managing doctors in rural health services is a very delicate balance. They are a full-time occupation themselves ... an enormous amount of work ... it's very difficult.*

The size of the town, and hence the number of doctors with admitting rights to the health service, has a bearing on the problem. In larger towns, where there are a number of GPs, the problem may be exacerbated by just one individual. In smaller towns, where they may be only one GP, the situation probably becomes a lot more personalised. It was recognised that in a serious conflict between the DON/HSM and the GP, irrespective of the right or wrong of the situation, the board, the HDWA and the community would support the GP. To have a GP in town is seen as very important and related to the town's standing. One respondent said:

> *The community thinks that any doctor is better than no doctor, and we should do everything we can to let the doctors do what they like to make them happy so they'll stay.*

If the choice is between the DON/HSM and the GP, most times the support will be for the GP. As pointed out by another respondent:

> *If it gets down to HDWA making a decision between who's going to go or who's going to stay, it won't be the DON/HSM who stays.*

This situation seriously erodes the trust the DON/HSM has in the stakeholders.

The impact of GP practice is enormous, and this has influence on all aspects of the management of the health service *and the relationship with the doctors can make or break a health service.* All respondents reported difficulties with GPs *withdrawing their services* or *over-servicing* or *wanting to perform inappropriate procedures* or *wanting the most*

expensive of everything. It is generally agreed that GPs can be the cause of *unbelievable stress levels.*

That the GPs resent the influence that the DON/HSM, a nurse, can have on their practice and income was a recurrent theme in the interviews conducted for this research. One respondent summarised the general feeling:

> *They see the current general manager as being a bureaucrat, as just a bureaucrat. But I think I'm lower than that, because I'm a nurse, and nurses don't tell doctors what to do.*

This raises the issue of professional boundaries and that of clinical autonomy. (See the discussion in Chapter 3.) The boundary between nursing practice and medical practice, often blurred, is even more so in rural health services. Political behaviour often ensues as the parties vie for influence. Most respondents reported stories of GPs trying to shape DON/HSM decision making by such political behaviour as inciting community protests, writing in the local newspapers, and lobbying the HDWA and the local Member of Parliament. Probably the only factor that prevents all out war, rather than a series of skirmishes, is that both parties essentially want the same thing: good patient care. Differing opinions about the process of delivering that care is the source of the conflict.

There were, however, DON/HSMs fortunate enough to work with GPs in an atmosphere of collaboration and collegiality who could confidently count on the GP for good practice, cooperation and support. Nevertheless, the respondents all agreed that the relationship with the GP is one of the most problematic areas of the DON/HSM role. It is also generally agreed that there is little support for them in this area. The board is reluctant to take a stand that may upset the GP and cause them to leave town. Rightly or wrongly, the boards view the GP as being more valuable than the DON/HSM. The GM is also reluctant to intervene in conflicts with the GP. As the GMs generally, do not have a clinical background, they are seriously disadvantaged in any debate involving clinical practice. The HDWA has also shown a reticence in becoming involved in any clinical practice dispute.

So the situation remains one of tension and conflicting vested interests. The issues remain that of boundaries between professional practice and access to limited resources. The influences the GPs exert on role of the DON/HSM are summarised in Figure 5.5.

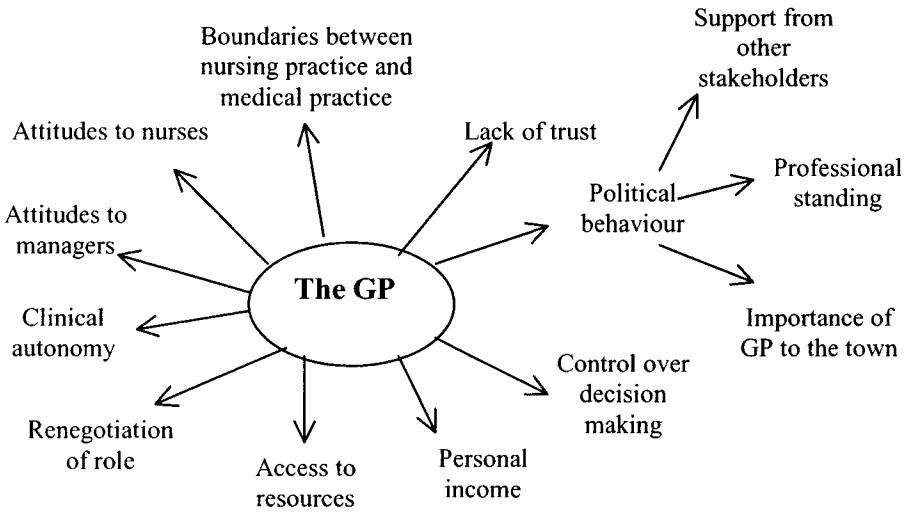

Figure 5.5: General practitioner influences on the role of the DON/HSM

5.3.5 The community

The community has a significant impact on the role of the DON/HSM. The health service is important for the town as it serves as a symbol of the town's standing. The DON/HSM is seen as the health service personified and, as such, is considered to be public property: *They think you're some sort of icon in some sense.* Thus the DON/HSM becomes the public image for the health service whether at work or not. Similarly, the DON/HSM is held responsible for all activities of the health service. It was generally agreed that the community still thought of the DON/HSM as the "Matron" and still expected the caring, motherly character associated with that role. It was also thought that the community regretted the passing of the white uniform and veil that was so much a part of the Matron persona. It was generally agreed that there was little understanding in the community of the demands of the DON/HSM role.

The need to be part of the community was identified by many of the respondents, but at the same time they acknowledged personal consequences of these demands. Many respondents reported membership of local service organisations as an endeavour to *get access to important people from another angle.* Thus such community involvement was seen mainly as a political manoeuvre, a way of influencing community opinion about health service initiatives. Nevertheless it was identified that *the visibility is very demanding, especially in a small town that you can't get away from.* As the health service was often the largest employing organisation in town, high visibility often caused pressure to employ particular individuals. This was particularly prevalent in town with high levels of unemployment.

In addition to unemployment levels, impacts on the role of the DON/HSM also arises from other circumstances in the community. For example, drought conditions in some areas have increased stress levels in the community with a corresponding increase in the incidence of depression and suicide and an increase in psychiatric admissions to the health service. Members of the community often turn to the DON/HSM for support rather than the GP as they are probably more accessible. One respondent referred to *people's expectation that you can fix everything and you can't.* That adds to the stress of the DON/HSM position.

The notion of the community, especially when viewed from the stakeholder perspective can be viewed from a different angle. Within the community, there are a number of organisations that must be viewed as stakeholders, and the DON/HSM is often seen as the linchpin for the activities of these often disparate groups. These groups include the Silver Chain, the police, the State Emergency Services, St John Ambulance, the Fire Brigade, the local shire council and many others. These groups often have different funding mechanisms and may cover different areas in the same district. The size and importance of this stakeholder group is illustrated by the story of one respondent who called a meeting of all such groups and had 36 separate groups attend.

In summary, the relationship between the DON/HSM and the community is multifaceted. The community has high expectations of the role and hence the person in the role. The DON/HSM also has an important function in facilitating the activities of many other groups

in the community that have a stakeholding interest in the health service. The DON/HSM is often the only common denominator amongst all these groups. The influences the local community exerts on role of the DON/HSM are summarised in Figure 5.6.

Figure 5.6: The local community influences on the role of the DON/HSM

5.3.6 General managers (GMs)

The relationship between DON/HSMs and the General Manager (GM) has been a difficult one since the restructuring of the rural health services. The position of GM has been characterised by high levels of turnover with reports of three GMs in the previous eighteen months not being unusual in some health districts. The relationship between the DON/HSMs and GMs has been made more vexed by an ambiguous reporting line. The direct-line responsibility of the DON/HSM is to the Chairperson of the board, and the relationship with the GM is represented by a dotted line only. (See Chapter 2 for further explanation.) The GM does, however, control the allocation of funds to the board and, hence, the health service so in this way has a significant bearing on the role of the DON/HSM. In districts where the boards were new or not functioning well, the GM has had much more impact at an operational level. As the GM role was also new, under the restructuring, there was considerable variation in how each saw their role.

How the DON/HSMs experienced their working relationship with the GM varied considerably. Some reported a very positive relationship with the GM. One group 3

respondent saw the GM as *the most amazing person because I mean there was nothing he didn't know.* A number found the GM to be *very important in the first while, when I was flailing and didn't really know what I was doing.* Some GMs where also instrumental in changing the focus of the DON/HSMs (especially those in groups 1 and 2) from that restricted to the hospital to a wider view of the strategic direction of the health service. Some GMs put infrastructure in place at the level of the district office to support the decision making of the new DON/HSMs, principally in the areas of financial and human resource management. Some GMs also functioned as a sounding board as the new DON/HSMs developed their understanding of the new role. As another group 3 respondent reported: *He couldn't necessarily solve my problems, but he would always listen and he would always give you a fair audience.*

Other respondents, however, did not see the relationship in such positive terms. The opinions ranged from those of indifference to irritation to antagonism to outright hostility. *I have a huge problem that we appear to be controlled...by the general managers* was a frequent comment. Most concerns related to the GM's knowledge of the DON/HSM's job, the power that the GM had in terms of controlling the allocation of resources to the health service and the GM's role as a gatekeeper of the information flow from the HDWA and the health service. Some reported frustration with GMs who would *not volunteer information.* Many of those interviewed for this research related incidences of making decisions based on their understanding of the situation only to find that the GM had not forwarded appropriate information or the information forwarded was incorrect. Being held accountable for decisions made under such circumstances created frustration and anger and eroded trust between the GM and the DON/HSM.

A number of the GMs, especially in the early days of the restructuring were former hospital administrators who had been forced out of their position by the restructuring. (See discussion in 5.2.1.) Many of the DON/HSMs, especially those in group 1 who had been involved in the removal of the administrators, felt that much of the conflict between the two roles stemmed from that time. There was certainly the feeling that the GMs used their power to make things difficult for the DON/HSMs who occupied positions that many GMs

thought was rightfully theirs. A recurrent theme was the perception that the GMs were *interested only in keeping the DON/HSMs in there in the position that they think they should be — under control.*

The credibility of the GMs was not high in the view of the respondents, and most expressed disdain for the GM's understanding of the GM role and how their role interfaced with that of the DON/HSM. One respondent commented:

> *I see very few general managers who have a real concept of what we're all about and what this role is all about and what we're actually doing. And really in most cases they don't care ... as long as it just floats along they are not really interested.*

There was also some scorn for the GM's' claim that they are the last accountable authority. As one respondent pointed out *if anyone's going to go in court it will be me or the person in this role.*

The relationship between the GM and the health service boards also impacted on the role of the DON/HSM. In some districts, the health service boards took a very strong stand, adamant that the line management of the DON/HSM position did not lie with the GM. One respondent in such a district told of a succession of GMs trying to assume more control in the face of strong resistance from the health service board. At the time of this research, the board was clearly still in control and also, to date, successfully resisting the move to a district board. In this particular case, there was a strong alliance between the DON/HSM and the health service board. In other districts, conflict between the GM and the health service board made working conditions very uncomfortable for the DON/HSM who was thus unable to place trust in either party.

Most respondents also reported that in any conflict between the DON/HSM and the GPs, the GM would be more likely to support the GP. Some respondents reported incidences where the GM had excluded them from negotiations with the GP. This created concern as these negotiations often had direct impact on the health service and, hence, the role of the DON/HSM. In other reported incidences, however, the GM removed themselves from

negotiations, leaving the DON/HSM with little support. It was generally agreed that as the GMs did not have a clinical background, they were at a serious disadvantage when trying to influence the activities of the GPs and had difficulty in understanding some of the issues.[2]

The GMs' lack of understanding of the DON/HSMs' role, particularly the clinical component, was a recurrent theme. The perception that *they're bean counters. They're not from nursing backgrounds* was a frequent comment. The generally held view was that the GMs only concern was with the management component of the DON/HSM job, and that they had little understanding of the "clinical imperative"; i.e. when there was an emergency there was no choice.

One respondent related how she had arrived at a district meeting, exhausted after being up all night for a maternity case as she had been the only midwife available. The GM could not understand why she had not refused to do it and failed to understand there was no alternative. As the respondent said: *The GM thought I was being some kind of stupid martyr. He had no idea.* Because the GM had little understanding of the clinical component of the role, it was generally agreed that there could be no understanding of the role as a whole or an appreciation of the conflicting demands, requiring minute-by-minute decision making.

A number questioned the need for a GM at all, claiming that the GM was *just another layer that complicates my day*. Most agreed that as they became to understand their role more, the GM had less of an impact. Despite some having positive relationships with their GM, most learned not to rely on the GM for support and information and managed to mostly avoid the GM by establishing informal networks directly into the HDWA. The sentiments of most of the respondents to the role of the GM are summarised in the following:

> *The GM has no direct control over me. Okay. I don't particularly like him. I don't particularly get on with him, and I think he does stuff all and he gets paid double my wage nearly.*

---

2 One GM was a registered nurse and a former DON/HSM.

The relationship between the GM and the DON/HSM is far from clear in organisational terms, and the influence of the GM on the operational activities of the DON/HSM varies enormously from health service to health service. The relationship between the health service board and the GM also moderate this relationship. Where there is a strong board and a good relationship between that board and the DON/HSM, the GM's influence is greatly restricted. In other districts, where the board does not have such a strong role, the GM is much more influential. The relationship between the GM and the DON/HSM in most areas, however, is not constructive. Most of the respondents saw the GM role as superfluous and the motives of the incumbents questionable. The influences that GMs exert on role of the DON/HSM are summarised in Figure 5.7.

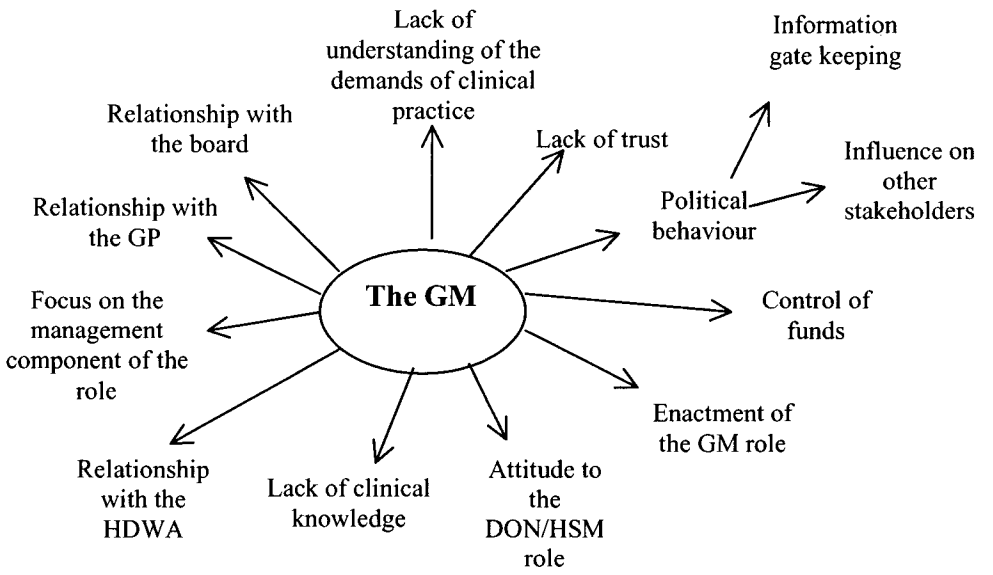

Figure 5.7: General manager influences on the role of the DON/HSM

5.3.7 The Health Department of Western Australia (HDWA)

The health services are funded by and managed for the HDWA. Although the GM is clearly understood as the agent of the HDWA, the DON/HSMs have direct contact with and rely on the HDWA for many components for their job. Frequent restructuring in the

HDWA associated with downsizing and subsequent changes in departmental responsibilities often makes communication with rural health services difficult.

Many DON/HSMs rely more on informal networks with individuals in the HDWA than formal channels. Those without such networks in place find accessing information difficult and trying. Group 2 and 3 respondents, especially, can see HDWA processes as somewhat mysterious. One group 3 respondents related the following story that illustrates the frustration and confusion that some DON/HSMs feel:

> *I was writing the plan for the MPS. I needed to know what to vest a building meant. I was writing to a solicitor in the Health Department and she'd keep writing back but not telling me what it meant. I must have e-mailed her twelve times. By this time everybody was getting involved. It was just this one simple thing that I couldn't work out. I eventually tracked down somebody in the HDWA who knew. I'd marry him tomorrow, I think. I found out eventually, but it took me a month.*

It is probably not surprising that there is a general sense that those in the HDWA have little understanding of what is happening at the service-delivery level in rural areas and even less understanding of the role of the DON/HSM. As one respondent succinctly put it: *They haven't got a clue* or, in a more extreme view: *The HDWA hates us.* The HDWA, however, *was a really big part of the job. I just couldn't really believe how time consuming it was.*

The frustrations, on the other hand, may be at a higher level thus compromising the community and threatening the credibility of the DON/HSM. The respondents reported many incidences where poor communication with the HDWA made their job more difficult than it needed to be. For example one group 3 respondent, new to the position, related how she had mobilised the community to raise money for a new piece of equipment for the health service. After months of work, the health service took delivery of the new equipment with reports in the local newspaper. The following week, the DON/HSM discovered that the HDWA was to provide a number of rural health services (including this one) with the same piece of equipment, in line with a policy decision announced two years ago. Because of a lack of a hand over when she took over the job, she had not been aware of this

situation. This one error compromised her credibility with the health service staff and the community and probably threatened future fund raising for the health service.

Of most concern is the working relationship between the HDWA and the DON/HSM. The respondents generally felt that the HDWA could delegate to the DON/HSM anything they chose, but the DON/HSM had no right of appeal. With structuring and downsizing in the HDWA, more responsibilities are devolved to the health service level. It may be argued that this policy to devolve responsibilities is in keeping with the philosophy of the government of the day, but it is apparent that the increased responsibilities are not accompanied with a corresponding increase in resources for their management. Such changes significantly impacted on the role of the DON/HSM, especially as many changes were unheralded and unexpected. Many claimed that the expectations of the HDWA were unrealistic, but also felt that *the HDWA doesn't seem to see it that way or care.*

Most respondents generally agreed that probably the most difficult and stressful part of the DON/HSM role was being accountable for clinical outcomes. Clinical outcomes were directly related to the practice of the GPs — something over which the DON/HSMs had very little control. Several respondents related incidents when they had concerns about clinical practice. All these respondents reported a disappointing and also very disturbing lack of support form the HDWA. As one respondent said *there's very little support for you. And clearly not from the HDWA ... so you are ...on your own.*

The issue that most respondents thought reflected the nature of the relationship between the DON/HSMs and the HDWA has been recent attempts at workplace agreements for senior nurses. There are elements of the proposed agreement that the DON/HSMs feel fail to recognise the scope and complexity of their role. This brought to light, in the view of the respondents, the true nature of the attitudes of the HDWA. The feelings of the group are probably best summarised by one respondent:

You know you feel totally devalued. And it's the HDWA that has devalued us. They are treating us like silly little nurses who won't create a fuss and who don't count for much anyway. That is the message I am getting ...yet we are holding the whole system together I believe. I think we're pivotal to the running of the health service in this state.

It can be argued that the HDWA has the ultimate control over the role of the DON/HSM. It was HDWA policy that created the role in the first place. It is, however, policy decisions at the HDWA level that continue to impact upon the role and the current policy of devolved responsibilities is continuing to shape the DON/HSM role often in unpredictable ways. The DON/HSMs' lack of control over these policy decisions creates anger and frustration at the health service delivery level with many of the respondents feeling isolated, unsupported and devalued. The uncertain communication channels between the health service level and the HDWA enhance this feeling. The influences the HDWA exerts on role of the DON/HSM is summarised in Figure 5.8

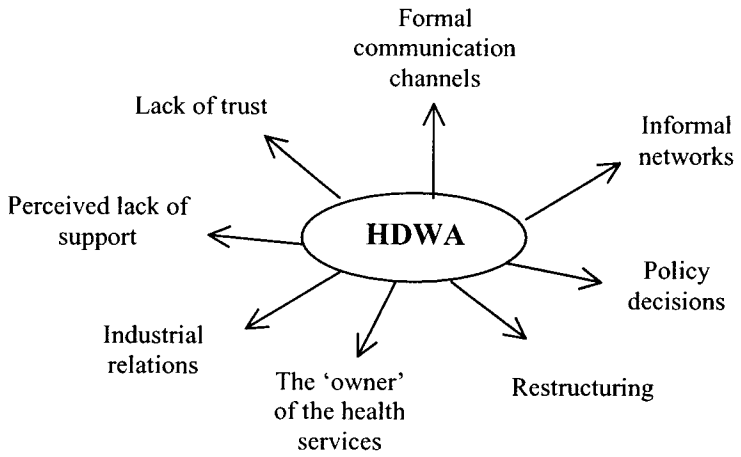

Figure 5.8: The Health Department of Western Australia's influences on the role of the DON/HSM

5.4 Stakeholders and the role of the DON/HSM

In order to adapt to the role of the DON/HSM, the respondents have to resolve the often conflicting demands of the various stakeholders. This has to be done by a process of negotiation because although the stakeholders have needs of the DON/HSM role, the

DON/HSMs also have needs of the stakeholders in order to meet the goals of the health service for which they are responsible. Nevertheless, this process of negotiation leading to the enactment of the role is difficult.

One respondent described the relationship between the stakeholders and the DON/HSM:

> *There's lots of people having input in, and they all want to drive. But ...they can't all drive, so they are all grabbing their bit. And that one little bit in the middle is just spinning constantly.*

Another respondent likened the situation to that of a wheel with the DON/HSM as the hub and the stakeholders as the spokes. In order to make the wheel function, they all had to collaborate and work towards a common purpose. The way that this was done, as a number of respondents identified, was through language. As one respondent said: *You're an interpreter service half the time.*

5.4.1 Language

There was the general sense that each of the stakeholders spoke a different language and as such did not necessarily understand the other. These languages emerged from the professional and educational background of the individuals and used words, abbreviations, acronyms, metaphors and technical jargon in a way that often made their conversation inaccessible to those without a similar background. The use of such language is often used to create a bond between members of one group and used to exclude non-members.

GPs use a clinical language that is understood by the DON/HSMs but is often inaccessible to GMs and boards. GMs used a management language that is often not understood by the GPs or the boards. One of the steep learning curves experienced by new DON/HSMs is the acquisition of management language. Boards and the community are often severely disadvantaged because of their lack of access to these languages and the health service staff are disadvantaged because of their lack of access to the language of management.

Because of their clinical background, the DON/HSMs spoke the language of the clinician and rapidly learned the language of management. This often put them in the situation of

serving as interpreter between stakeholders. To illustrate, one respondent reported on the decision to purchase endoscopic equipment, a large expense for a rural health service and pointed out that:

> *It's really difficult to make a purchasing decision on pieces of equipment when you don't actually know what that equipment's there for — what it actually does. The GP knows, but the GM and the board have got no idea. I've got to tell them.*

Another respondent further illustrated the situation:

> *What does palliative care mean to a general manager? What does it mean to a practically based clinical nurse with management skills. Two different things I can guarantee.*

Although everyday language is common to all groups, the understanding and use of everyday terms is often different. As one respondent suggested: *Get them all to explain health care, and see how many answers you get.*

A number of respondents reported how various groups used language in an attempt to influence other. GPs, for instance, tended to intimidate GMs and boards with the use of clinical language. GMs and boards often turned to the DON/HSM for a translation. This often placed the DON/HSM in a pivotal position as the channel of communication between the various stakeholders. It also allowed the DON/HSM to influence decision making in a unique way.

5.4.2 The isolation of the role

The image of the DON/HSM as the hub of the wheel, spinning constantly reinforces the notion expressed by a number of respondents that the position was an isolated one, and that deciding who to trust was difficult. Both work and social relationships and the choice of friends became problematic. As one respondent put it: *You're not in this position because you want to be liked.*

There was also the sense that that the stakeholders claimed good decisions and bad decisions were blamed on the DON/HSM which further added to the sense of isolation and doubt over who was trustworthy. One respondent said:

You feel isolated as you have to make the decision, and you know you'll wear the outcome of it. I don't have a huge problem with wearing the outcome of decisions that I make as long as I can control some of the inputs ... then that doesn't always happen.

There is also a sense of isolation in that everybody is doing the job differently. Each health service is different; i.e. the health service requirements of the district, the nature of and dynamics between the various stakeholders and the history of the DON/HSM role all contribute to make each DON/HSM role unique. Often, a DON/HSM faced with a particular problem will contact others and find the problems or the alternatives possible as a solution peculiar to their particular health service. Similarly, a problem for one DON/HSM may be the problem of the district office for another. A group 3 respondent explained:

so we're all picking up different aspects of the job. There's no clear-cut guidelines as to what's ours and what's not.

Where the DON/HSMs turn for support is an important influence on how they negotiate their way through the maze of often incompatible stakeholder demands.

5.4.3 Support

The respondents generally agreed that support for their new role was something that was not offered, but instead something that they had to actively seek. The need to establish a support network was seen by many as one of their first priorities. The ease with which this network was established depended to a great extent on their knowledge of the health care system and for this reason was often easier for those in group 1 than those in the other groups. The most support came from those in a similar position. When the position was first implemented this networking was informal, and it was a case of trying to find somebody who knew more than you did.

The HDWA did put in place several educational programs to meet the learning needs of those in the DON/HSM role — including a sponsored university-based diploma program and an ongoing training program. DON/HSMs were also encouraged to undertake accredited programs in universities. Just over half of the respondents had completed the university-based diploma program and just over a third had completed or were enrolled in

accredited postgraduate university programs. Most considered these programs to be of benefit but found difficulty with formal study, often in distance-education mode, while trying to cope with the demands of their new role. Many reported that one of the best parts of the HDWA programs was that it put them in touch with others in the DON/HSM role

As the role became more established, more formal networks were set up. The DON/HSMs of some districts meet quite regularly as a way of debriefing and helping each other out. This has been a great support for many as an environment of trust and confidentiality has been established. A number describe such meetings as the only place where they could actually say what they felt without fear of repercussions. It was also identified that *you meet other people who have the same job title. There are very few people that do my job.*

Other district meetings, however, have not developed the same degree of rapport with the nature of the meeting ranging from boisterous to very polite. One respondent who went to a meeting in another district complained that *I actually found it pathetically boring and quite polite and correct compared to what we have here.* Another respondent suggested an explanation for the reserve that is common in a number of meetings:

> *Nurses believe they have to be seen to be coping, and you don't really share a whole lot of your problems with other people. Also while all the jobs are the same, they are also different. Many of the problems you have are with personalities like one particular board member. It gets a fine line between what is sharing your problems and what is gossip. You don't really want to wave the town's dirty linen for everybody to see.*

Other respondents, when asked where their support came from offered various responses. The disparate groups accessed by the DON/HSMs indicate the diverse influences, however informal, on the shape of the role. Those chosen for support were turned to because the respondents believed them to be trustworthy. These supports included spouses and partners, friends outside the health service, other nursing staff, the administrative assistant, the Chairman of the board and, in some cases, the district office. Others sought help wherever they could find it. One respondent reported how

I just rang around the state. I just rang different hospitals and said, you know, "Oh can you help me? We don't have anyone here that knows and I can't work out why this has happened, can you help me?" And some people did, and other people didn't and [I] just kept going until we got help. And we finally understood those systems and they changed them all.

How the DON/HSMs interpreted the influences of the stakeholders is summarised in Figure 5.9

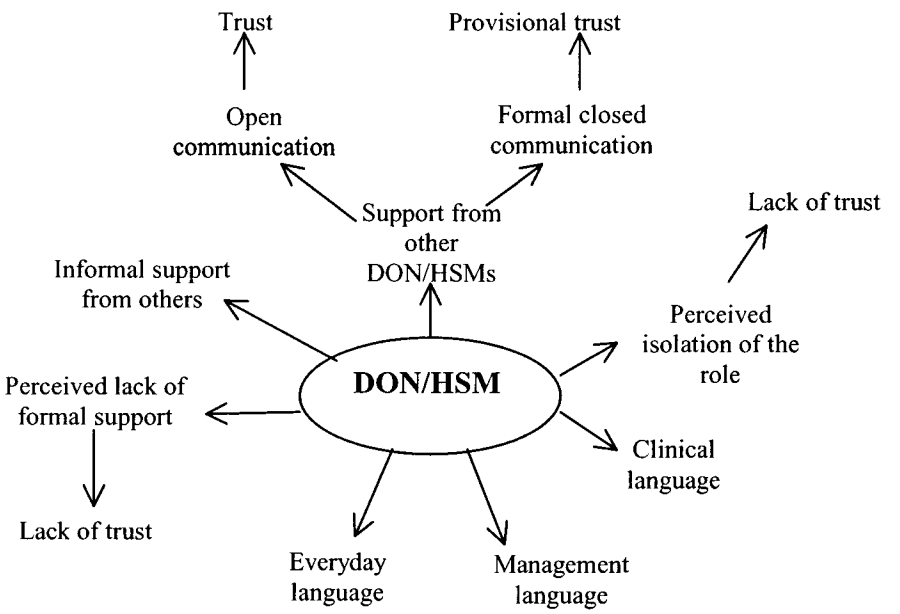

Figure 5.9: Stakeholders and the role of the DON/HSM

In order to adapt to and enact the role of the DON/HSM, those interviewed for this research were required to integrate these divergent influences, the way they came into the job, the pressures exerted by stakeholders and the effects of their support mechanisms. The next chapter will present the findings of how this process took place.

Chapter 6: Findings regarding personal elements

6.1 Introduction

This chapter continues to describe the findings from the analysis of the text of the 36 interviews conducted to gather data for this research. It focuses on the respondents' statements about the content of the job and how they developed their role. Consideration is given to the clinical and management components of the role and the influences on the respondents as they endeavoured to integrate these demands into a coherent role.

6.2 The clinical component of the DON/HSM role

The clinical component of the DON/HSM role was influenced significantly by the size of the health service. In the small health services, with hospitals of 20 beds or less, there was a 2+2+2 staffing configuration; that is there were two nurses on duty for each shift (morning afternoon and night) in any 24 hour period. Twenty-eight of the respondents interviewed for this research worked in such health services.

In these health services, the most senior clinical nurse on the staff, apart from the DON/HSM, was usually a Level 2, and frequently they worked on a part-time basis. Prior to the implementation of the DON/HSM role, the DON in such health services usually formed part of the nursing establishment, working rostered shifts on the wards. When the DON/HSM role was introduced, it was usual that the boards expected that they maintain this clinical role. Many found that with the demands of the management component of the new role, this was extremely difficult. Those in the new DON/HSM role found they had to renegotiate their role, both with the nursing staff and the board. Nevertheless these DON/HSMs in small health services normally maintained some degree of direct involvement in day-to-day delivery of clinical services.

Those in larger health services with hospitals of 20 to 60 beds (eight of the respondents), had a larger staffing establishment with Level 3 clinical nurse specialists and, in one instance, a Level 4 on the staff. These DON/HSMs were able to delegate more of the clinical practice element of their role, but were still required to redefine their clinical responsibilities.

A number felt that the importance and demands of the clinical role was not understood by some of the stakeholders, most particularly the Health Department of Western Australia (HDWA) and the General Managers (GMs). Some felt, that because the role had a clinical component, it was not seen as a "real management" role. It was seen as a lesser role particularly by those in senior management whose policy decisions had such a serious impact on shaping the role. It was thought that because those in the senior position generally did not have a clinical background, they either overlooked the clinical component of the role or did not consider it to be important. Either way, most respondents thought that *actually having a clinical component in the leadership position is degrading of the position.* The result was that the *position is less valued.*

There was also the sense that the clinical skills that the DON/HSM brought to the role was not viewed as important by some of the stakeholders. One group 3 respondent, with expert critical care skills, complained that *the board felt that my clinical experience was of no practical use in this hospital.* There was a generally held opinion that the stakeholders (such as GMs, the board and the HDWA) were much more concerned with a balanced budget that they were with the standards of nursing care. Although to be a Registered Nurse (RN) had to be an essential selection criterion for the position of DON/HSM, most respondents felt that their clinical skills were not valued and that the management component of the role was the only element considered important. Many respondents pointed out the paradox of this situation. Most brought clinical skills to the position, but few brought management skills.

Notwithstanding the views of stakeholders, all respondents identified the importance of the clinical component of the role. How this role was enacted showed some marked variations.

How the DON/HSMs managed the clinical component of their role was very much left up to their own judgement. There were no guidelines to follow, no advice given by the boards and little help from other DON/HSMs who were struggling with the same problems. The clinical component of the role evolved over time, shaped by a complicated interface of circumstances such as staffing levels, the available skill mix, the workload and case mix, the preferences and skills of the DON/HSM, and the expectations of the stakeholders.

In small health services, most respondents tried to avoid doing regular shifts on the wards. A number of group 1 respondents tried to maintain working regular shifts as they had as the DON, but as the management component of the job grew, they were unable to keep this up. Nevertheless, some respondents were still doing 16 hours a week clinical. Most, however, reported *if they're short-staffed, I'll go on the ward and I'll do the occasional shift.* The majority were on-call 24 hour a day, seven days a week and were being called for all emergency and midwifery cases. Many were also called to do x-rays. The difficulty in doing a days work after being up half the previous night because of an emergency was identified by many of the respondents.

Others had introduced flexible rosters with no shift overlap and had employed patient care attendants (PCAs) — untrained staff who required registered nurse supervision. Such innovations often required the DON/HSM to be on the wards at times when there were no other RNs available. The availability of a GP also affected the clinical role of the DON/HSM. A group 2 respondent in a small health service summed up this situation

> *In the last five years, two years we've had no doctor at all in [the town]. So I was it. On-call twenty-four hours a day. So any emergency that came in, they rang me.*

The DON/HSM of one of the larger hospitals explained their clinical role in different terms. Because they had more senior nursing staff in the health service, they were able to delegate much of the hands-on clinical work. There is usually enough staff that they were not required for clinical relief. Most, however, remain on-call and were still usually called for emergencies, especially at night.

How clinical demands or the clinical imperative could suddenly take over at any time was explained by a number of respondents, irrespective of the size of the health service. When an emergency arises, that becomes the priority:

> *When it happens it takes over, and you don't do your management stuff at all. That has to wait, even if it's urgent stuff; it doesn't matter. It has to wait.*

Many commented on how frustrating this was because it made planning a workday so difficult. Even though *the clinical part is a very small part in the every day to day* it can very rapidly *become a priority.* This is a factor in the role of the DON/HSM over which they have no control.

Many identified the loss of clinical skills as an important consequence of taking on the DON/HSM role. While most can and do step in and help during an emergency, keeping up-to-date is a problem, especially in the area of new technology. For example:

> *If the staff need a new machine, I can get the money to get them the new machine, but I don't have the time to know how everything works all the time. Just don't have the time.*

Most try to keep up-to-date by attending staff development sessions held at the health service with the other clinical staff and having twelve-month updates in areas such advanced life support, neonatal and cardio-pulmonary resuscitation (CPR). The difficulty in maintaining such skills because of the lack of day-to-day practice was identified. One respondent, discussing new technological innovations observed:

> *In an emergency, I would have to stop and read the instructions because I am not using these things on a day to day basis.*

All, however, agreed that *issues relating to clinical practice are an important part of my job*, and the necessity to make every effort to maintain clinical skills was identified by most regardless of the size of the health service. On respondent, the DON/HSM of one of the large health services, explained how she was *often in the building later than my Level 3s, and if there was a spare pair of hands required in an emergency I still feel it's very necessary for me to be able to do that.*

Another group 2 respondent in a large health service explained how clinical skills were important elements in her relationship with her staff. Nurses are the biggest component of the staff — they work across all shifts, and are involved in all life threatening emergencies. Clinical skills allows the DON/HSM to have *loyalty, camaraderie or something ... knowing what it felt like to be the nurse ... in that situation. I think to be able to share those moments of trauma is important because the nursing staff would be the ones who face it most of the time.* To have that understanding of the demands of clinical practice was seen an extremely important when it comes to empathising with and debriefing staff.

In smaller hospitals, clinical skills were seen as even more crucial in maintaining a relationship with the nursing staff. Most found that *if you do a bit of clinical work with your nurses then the rapport's a hell of a lot better.* Clinical skills were seen as an important part of the credibility of the DON/HSM in the role. A DON/HSM who was not able to demonstrate good clinical skills, especially in a smaller health service, lost credibility with the nursing staff and also the GP, which seriously compromised their ability to carry out their role.

Regardless of their "hands on" clinical role, all of the respondents saw themselves as having a clinical leadership role in relation to all the stakeholders and were *expected to be an expert resource person ...* with *... access to expert information and to act on it and make decisions.* In addition, the DON/HSM was expected to be *the expert person as far as the doctors are concerned and am spokesperson for the hospital on clinical matters.*

All the respondents saw the clinical component of their role as being of vital importance. The need to redefine this role within the context of the DON/HSM position was seen as necessary but also problematic. The change in their clinical role with the implementation of the DON/HSM was described by the group 1 respondents as a very difficult time. Despite the expectation of the board that the DON/HSM would maintain the same level of clinical input (in some cases four days a week), it became readily apparent to the respondents at least, that this would not be possible. Because there was no precedence for the role, the new DON/HSMs found they had to take a stand and try to negotiate a role that wouldn't get

them *in a real frazzle.* The nursing staff, the board and often the GP did not like this change, and most respondents recalled varying degrees of opposition and the need to be *pretty assertive.* The GMs were quite disinterested, and their advice was *to work it out for yourself.* All found this time stressful as they had no allies and felt very isolated. Confidence in one's judgement and ability to stick to one's decisions in the face of opposition was necessary for survival.

The clinical role was not just as a result of negotiation with the stakeholders. It could be influenced by factors beyond everybody's control. A current nursing shortage is having a notable bearing on the clinical component of the DON/HSM role across both the large and the small health service. As one respondent in a large health service pointed out:

> *We are having difficulty finding enough nurses with the skills that we need, and I am having to do more clinical than ever before.*

In some health services, the nursing shortage is making demands on the clinical skills of the DON/HSM — skills that have eroded to a certain extent due to the time away from "hands on" clinical practice. One of those in group 2 and in a large hospital described how her direct clinical role had evolved into one of helping out in emergencies. She now finds the necessity to take a much more active role, but observed:

> *I don't have the skills like I used to have, and I don't have the expertise or the knowledge of drugs or the quickness to get the stuff out like I used to be able to. I find this stressful and not good for my ego.*

Despite the difficulty in maintaining a workable balance between the management and clinical component, all the respondents were very protective of the clinical element of their role. One group 1 DON/HSM in a large hospital related the following:

> *Our previous GM tried to remove the clinical component of my role, but I jumped up and down and explained in detail to the board what would happen if it wasn't me, the nurse, making decisions. Because we are so far away, and although I don't carry a clinical load, when all hell breaks loose, I am a nurse. I am registered, and I can do any job in that hospital. And that is a very comfortable position to be in.*

The respondents, despite the directions in which their new role may have been taking them, still saw themselves as nurses. Typical comments were:

> *I will never ever be not a nurse. I will always be a nurse. But my primary function is a manager.*

To return to a solely nursing role, either as a clinical nurse or a DON role, was not seen as desirable by most of the respondents, however. As one group 1 respondent said:

> *I could never give up the management part of it now, I don't think, any more than I'd really like to give up the nursing part of it entirely.*

This raised the issue of how the DON/HSMs now perceived themselves. The generally held point of view was summarised by a group 3 respondent:

> *I still see myself as a nurse, but as a manager and a nurse ... but what I do really is management.*

As the DON/HSM role was new, the respondents had no previous experience on which to call when enacting the role. How each performed the clinical component was at the discretion of the individual and how they interpreted the demands of their role. The clinical component evolved over time, in response to numerous influences. The influences described by the respondents are summarised in Figure 6.1.

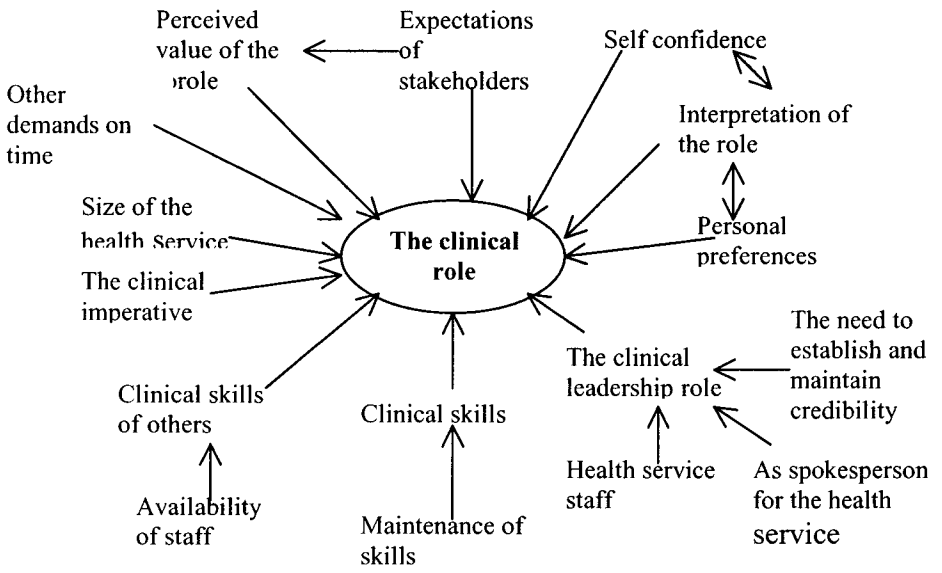

Figure 6.1: Influences on the clinical role

6.3 The management role

The management component of the job was daunting to most of the respondents. Some had more experience in the area than others, drawing not only on their previous positions in the health care industry but also other experiences in business. Some had experience in managing small businesses and in farm management. For the majority, however, this was their first experience in general management, being responsible for all aspects of management for the whole site. There was only one respondent who had, at different times, held the position of Director of Nursing and also that of Administrator in the Western Australian health care system. Most of the interview content around the management component of the job related to the learning requirements that this presented.

Nearly all of the respondents described areas of concern in which they had to rapidly acquire expertise. Respondents reported learning priorities in a wide variety of areas including, but not limited to, human resource management, dealing with unions, financial management, writing annual reports, business plans, needs analysis, strategic management,

developing key performance indicators, contract negotiation and legal requirements. As many said: *I was really drowning ... for a long time.*

Support during this learning time was variable. The HDWA sponsored a university-based diploma program and a leadership development program that a number reported were extremely valuable. Just over half had completed one or both of these programs, and they benefited mostly those in groups 1 and 2. The HDWA continues to offer incentives for those wishing to undertake postgraduate studies in health services management, and several of the respondents are currently enrolled in such programs.

Those in group1 who had received a good hand-over from the administrator found the assumption of their new responsibilities to be much easier. The support received from the GM varied from district to district, dependent upon personal relations with the GM and the GM's interpretation of their role. A number found that their biggest support was the administrative assistant, and claimed that without a good administrative assistant the job was all but impossible. Many, however, found that *I just had to work it out for myself, ringing all over the state hoping that somebody knew more than I did.*

Although the DON/HSMs had total responsibility for the management of the health service on both an operational and strategic level, the content of their management role showed a considerable amount of variation across health districts. This variation was dependent on the support they received from the district office that was managed by the GM. Some of these district offices provided considerable support, assuming the responsibility for such management procedures such as the payroll. Some also provided information systems and support for financial decision making. On the other hand, some did not, leaving the responsibility for such things with the DON/HSM. The learning requirements for DON/HSMs in many areas ranged from having an understanding of the process to actually having to perform these processes themselves.

Managing change became a large part of the role and the sole responsibility of the DON/HSM. The first change with which they had to deal was the implementation of the role itself. As the stakeholders — principally the board as the employer and the GM as the

agent of the HDWA — did not have a clear idea of how the role should look, the new DON/HSMs had to very quickly establish their priorities and then negotiate this understanding of this role with the stakeholders. Doing this concomitant with learning new skills and when previous experience was of limited use was, at times, overwhelming.

Those in group 3 often had a more challenging time. Although many assumed the role after it had been in place for some time, and there were other DON/HSMs with experience on whom to call, the different influences on each health service still made it necessary for them the re-invent the role. Many took over health services that were is disarray with the management component of the job having been neglected for some time. This neglect was often as a consequence of a rapid turnover of DON/HSMs and the position being filled in an acting capacity — usually by a Level 2 clinical nurse who had little knowledge of management procedures and little desire to learn. The need to quickly establish a sense of order was paramount, and again the need to take action while still learning and trying to understand the demands of the role was immensely difficult. Management knowledge, particularly in the areas of human resources and industrial relations, that could have an immediate impact was important in establishing credibility with the staff in such a situation. Payroll, worker's compensation, shift lengths and related issues were of great concern to all staff. Those still acquiring such knowledge were at a significant disadvantage.

The second major area of change with which the DON/HSMs had to deal was the change of structure of the health service — principally, that of the implementation of the MPS. The amalgamation of many services as a requirement for the MPS service was very threatening, not only for the staff of the various services, but also for the local community. Many in the community saw the integration of services under the MPS structure as a loss of services for the town and also as a loss of control over those services. Resistance to the MPS was a strongly felt in many areas.

Some learning took place in areas that were not quite so readily associated with the management function. The operation of large equipment was particularly challenging, with boilers being frequently mentioned. One group 2 respondent reported having to learn:

> *...what boilers I have, and what steam generators I have and what they do. I know exactly what my backup generator looks like, and where the battery packs are and everything I need to know.*

Another group 3 respondent told of how:

> *I learnt how to bleed a boiler ... so that we could have hot water in the morning and at night until we flew the plumber in.*

The management systems in place when the DON/HSM role was implemented were often inadequate, and the information systems made it even more difficult when trying to learn a new role. Many reported frustration at being presented with a figure relating to say, nursing salaries, and having no idea of how that figure was derived. The HDWA attempted to put in place more transparent systems, particularly in the area of financial management. These systems, however, took some time to develop and were frequently changed — often in response to restructuring and a change of staff responsibilities within the HDWA itself.

New DON/HSMs at the service delivery level who were trying to learn the intricacies of financial management and reporting requirement found these constant changes trying and confusing. For example, in these new innovations there was the implementation of electronic systems with a change from cost account to accrual accounting methods, and the DON/HSMs were made responsible for accounts payable.

With the introduction of new systems, some DON/HSMs inherited errors from the past. One respondent told of how she spent her evenings for months learning the electronic payroll system and then tracking down errors made by the previous administrator. What disturbed her most, however, was the readiness on the part of the other stakeholders, most particularly the GM, to assume that the errors were the result of the incompetence of the DON/HSM. She reported that:

There was a bit of a witch hunt going on to make me accountable ... She's only been in the job six months, and here she is $90,000 over on payroll, so [we] can't have a nurse running a hospital.

There is a general sense that the management component of the role (at the time the interviews for this research were conducted) and the role of the hospital administrator (when the DON/HSM was first implemented) can no longer be seen as equivalent. The management role of the DON/HSM has grown considerably in scope and depth. Changes in reporting requirements and the expansion of services such as the implementation of the MPS — with the hospital, HACC and hostel and coming under one management — have changed the management role considerably.

The importance of the management role and the responsibility it entailed was recognised by the majority of the respondents. It was recognised that good management was necessary if some of the smaller health services were to survive. This point of view was summarised by one group 3 respondent who observed:

If these places don't survive because they are not managed well then the effect on the community down the track will be disastrous.

There appeared to be considerable differences in respondents' understanding of the management role. When asked about the management role, some discussed the demands of reporting requirements and the need to spend a lot of time in their office. They clearly saw their role in terms of completing required administrative functions. Others, however, took a much broader perspective and discussed the strategic direction of the health service and its role in the community. Their focus was much more on the leadership element of the management role and was more concerned with motivating the staff to better meet the needs of the community.

It could be concluded, therefore, that there is some discretion in the way the management component of the role was enacted. Some stakeholders (for example the GM and the HDWA) were much more concerned with the administrative functions, and this was certainly the most measurable output of the role. The expectations of the other stakeholders were less clear and varied from health service to health service. The DON/HSMs'

interpretation of the management component of their role looks to be influenced by the expectations of stakeholders but moderated by their own personal preferences and their assessment of their skill levels and learning needs.

Most of the respondents reported that they liked that management role because the resource-allocation decisions the role entailed gave them a control over health service delivery in an unprecedented way. Some were more comfortable with some elements of the role than with others. Some enjoyed the administrative component, having developed good computer skills and skills in the use of spreadsheets, while others continued to find these demands difficult. On the other hand, some found the management of staff and making decisions in the face of the often conflicting demands of individuals to be the most testing. The influences on the management role as described by the respondents are summarised in Figure 6.2.

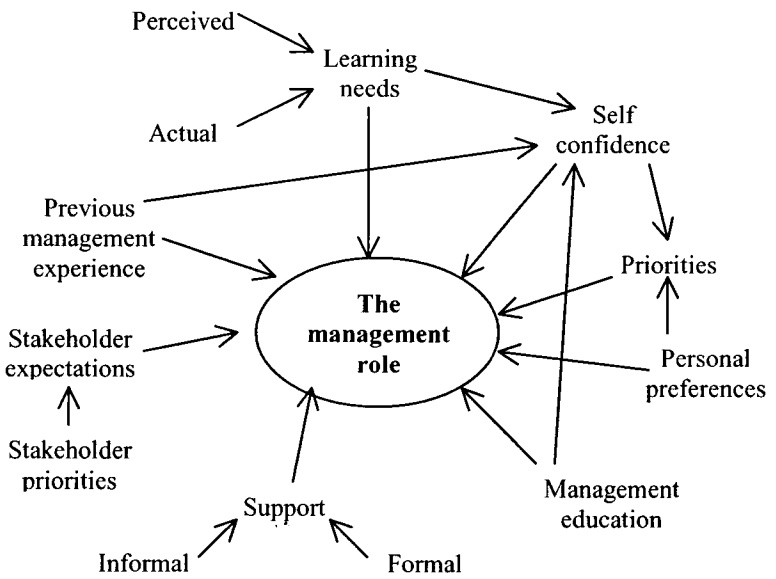

Figure 6.2: Influences on the management role

6.4 The clinical and management interface

All respondents saw the interface between the management and clinical components of the role as challenging. The respondents concurred that the two components were not in conflict but rather complimented each other, with both being essential to the delivery of a good health care service. The main issue was time constraints and the necessity to establish priorities. It was generally agreed that both components of the role did not have clearly defined limits and the amount of work that they entailed could, in practical terms, be infinite.

The decisions about how best to spend their time were on two levels. First, the respondents had to come to a personal decision about priorities. This involved developing a clear understanding of their job and what it entailed. This was not easy given that the role was new and their own managers did not have an appreciation of the role, their skills in many areas were at a basic level, role models were few, and the content of the role kept changing with new reporting requirements and the implementation of MPS services.

Second, this decision had to be made in the face of often conflicting demands of the various stakeholders. Choices regarding priorities were often met with hostility from stakeholders who saw the priorities of the role in different terms. This clash is illustrated by the following story from one respondent:

> *We had [a] significant [Annual General Meeting], lots of dignitaries coming for it... A big thing for the new board. I only had one enrolled nurse on the ward ... There weren't too many patients and I was in the hospital, so I thought that's fine ... A patient who had had an overdose and was unconscious was brought in ... I excused myself ... ended up having to transfer him out. I was absolutely stressed ... he was just barely functioning. Got him there, got home and got greeted with "You should have been there. You're the manager, and you had a responsibility ... I'm disappointed...". I said "I had a man that was really sick, that was life threatening..." And I got told "Oh I suppose you've got a duty of care to them". And that was it. That's how I got exonerated for doing what I had actually done.*

Another respondent explained the difficulty in accommodating these conflicting demands:

> *Yeah one minute I'm out with patients dealing with a ... I don't know, an MVA, kid screaming, blood everywhere, and the next minute I'm talking to some tosser in the Health Department about budgets. It doesn't work. You know my brain's still out there, and then the phone rings and I get dragged out of there ... They have no idea.*

The approach that the respondents took to resolving these conflicts varied. The size of the hospital had an important bearing because it increased the options the DON/HSM

> *There was no way that I could continue with the same amount of nursing that I had been doing as the DON.*

In the small health services, the option of essentially delegating one component of the role was not possible. Other approaches had to be explored. One group 1 respondent in a small hospital told of how at times of high demand in the management role, such as the annual report, she tries to work full-time on the administrative role. But that also presents difficulties as *people thought "well you're not on the wards, so you wouldn't know what it's like to be on the wards".* Another respondent who used the same strategy complained: *I've got a couple of young staff that just like to think that they know a little more than you do because you sit in a office all the time.*

Most respondents, especially those in small hospitals identified the need to *make a distinction between the two roles for the sake of keeping up with the paper work* and that *if you constantly made yourself available for clinical — which is, I guess, what most nurses like to do — you get so far behind.* One respondent tried to manage the distinction between the two roles symbolically by designating management days and clinical days. On the clinical days she would wear a uniform to work and on other days "civvies".

That the DON/HSM role has evolved over time in the face of increasing management demands was a common theme. The role has been shaped by external demands despite conscious decisions being made about the enactment of the role by those in the role. Those who tried to separate the role, as the respondent in the previous example, found that as the management component of the role expanded, it encroached more and more on their

clinical role. Despite intentions to the contrary, management demanded more and more of their time.

It was apparent that not all of the respondents saw this growth in the management component of the job in the same way. Some clearly resented it, while others were happy with their new responsibilities. Most agreed, however, that despite management taking the biggest amount of their time *patients always come first, so that's what would win in the end. The clinical would always win over management.* Most respondents concurred with the following statement:

> *We're here for the customers. Therefore, if there is a customer need, it becomes the top priority, and I try to fill that need in any way if I have the ability to do it.*

All respondents clearly identified the customer as the patient.

Regardless of the DON/HSM's personal view about the nature of their role, the need to defend this view against the demands of the stakeholders was reported by many respondents. This often caused a regrettable amount of conflict and took perseverance over time to enforce the point of view. The need to *stick to one's guns* in the face of opposition and attempts at manipulation was seen as an ongoing component of the role.

Despite the best attempts of the DON/HSMs, the balance between the two components of the role remains complicated and unresolved. One respondent described the resolution of this conflict in terms of what could be delegated and what could not be. Because there are other RNs on staff, the clinical component — the actual hand-on — can most of the time be delegated and then the management component — which nobody else wants because of its complexity and conflict — becomes, by default, the priority. But as a respondent pointed out:

> *But you didn't really think about it too much. It was a matter of taking this huge job and getting rid of the parts that you could in order to make a job that was possible to do. The job was essentially created by what could be passed on to somebody else.*

This reflects the view that the role is shaped, not so much by a grand vision of the role held by the DON/HSM, but by the everyday pressures of the job. Small incremental decisions, often made in a conflict-resolution situation, take the role in different directions. This reactive nature of the role was recognised by many of the respondents, as was the ongoing frustration of having to deal with new problems on a day-to-day basis. A group 3 respondent described the this frustration like so:

> *If you want to be a rural DON/HSM you have to be content to be a reactive manager. It's almost impossible to be a proactive manager because you just deal with issues all the time after they've occurred. You just spend too much time putting out bushfires caused by somebody else.*

6.5 The DON/HSMs and their role

The complexity of the role and the characteristics of stakeholder demands have led to the role of DON/HSM being developed in different ways in different health services. The notion of a generic description of the DON/HSM role became increasingly problematic. This section reports on the influences on the enactment of the role and the attitudes of the respondents to their role

6.5.1 Enactment of the role

The enactment of the role was influenced by the way in which the individual respondents coped with the demands of the job. All considered the time-and-effort demands of the job to be huge. A typical comment was:

> *You're supposed to work a hundred and fifty-five hours in a four-week period. Well some weeks you can work that in two weeks.*

The biggest challenge recognised by most, however, was integrating the conflicting demands of the stakeholders into a coherent plan for action. It is how the individual DON/HSMs integrate these demands that has led to the role being interpreted in different ways. One respondent — who had just finished mowing the lawn of the hospital — complained that he could never *decide whether the job is management, jack of all trades or nurse.*

There was also the general sense the role got harder, not easier, with time; and the longer you were in the job, the more people expected of you. When the DON/HSM was new to the role, people tended to be more tolerant and moderate in their demands. Later, as the DON/HSM became more established, demands increased. There was also the sense that the longer in the job, the deeper was the understanding and the more complex the job became. The job evolved as the incumbents' skill level and understanding grew.

In keeping with this notion, the need to be flexible was identified as essential by most respondents. There was a requirement to be constantly reflecting on practice and then being prepared to change what did not seem to be working. This constant tweaking of the role was seen as one of the reasons the role was being enacted in different ways in different health services. One respondent said of this process:

> *Because it's a new role and people are doing it in different ways ... they're trying things out ... They're not quite sure whether that's working or not, but while ... it's working you stick with it.*

There was, however, a degree of insecurity and uncertainty, with another group 3 respondent commenting

> *Perhaps you might not want to share because you're not quite a hundred per cent sure that's the correct way to go.*

One element of the job that is rarely recognised, but that many of the respondents found most difficult, was coping with emotional trauma. Some described the emotional trauma as one of the worst aspects of the job. The way that different DON/HSMs coped with this element of the role was also viewed as one of the reasons that the role took different shapes. Those who found the emotional component of the job hard may have used the office and administrative work a handy refuge.

Most respondents related stories of traumatic emergency situations involving injury and death. Over many hours, they had managed the emergency, counselled bereaved relatives, debriefed staff and finally got home, often late at night to think: *Who'll debrief me?* Due to

confidentiality issues, most find that they have nobody to talk to. Some of the respondents found this to be very difficult.

The demands of the role were complex and were interpreted in different ways by various respondents. The most common theme, however, was the sheer size of the job and the time it took to do it. All respondents spoke of working long hours, both at work and at home, and the difficulty of balancing the demands of the job with a social life. There were some differing opinions, however, about the options that the DON/HSM had in shaping the role in the way that they chose.

Some held the view that there was a considerable amount of luck involved, that it was *the luck of the draw.* The availability of suitable staff, the attitudes of the GP, the nature of the board and the input of the GM — despite the best of intentions — were seen as being largely beyond the control of the DON/HSM. Others took the view that each DON/HSM could essentially create or invent the role in the way that they wished. It was seen as up to the DON/HSM to *assert their authority* and change the role in the way that they chose. Still others took the view that the role was negotiated, reflecting the needs of the various stakeholders, the role being developed in a way that reflected some sort of consensus. Nevertheless there was still the notion that the DON/HSM role had a degree of autonomy and the shape of the role was, in the final outcome, essentially theirs.

The size of the health service was, once again, seen as having a bearing on the way the role was enacted. In a larger health service, and a correspondingly larger budget, there were more options. In a small health service, locked into a 2+2+2 staffing configuration, the discretion in the budget is limited and options are less. Given this discretion, however small, there was the concern expressed by a number of respondents that they were not doing the job as well as it could be done because the hours available to them were insufficient or they were making the wrong priority choices. One respondent provided this point of view:

I think there's a lot of things you're not doing completely because you have to skim over some things. Whether you're prioritising those correctly or not concerns me a lot. The general opinion was that you have to choose what you want to do well, but you can't do it all well.

The respondents generally agreed that in order to shape the role, the need was for the DON/HSM to have a clear idea about the role, and there was awareness that it was the DON/HSM who must make this choice. This was often extremely difficult for newcomers to the role. Although the job often became more difficult with time, as those in the role developed more understanding of the role's scope, that newcomers were more vulnerable to the manipulation of stakeholders was acknowledged as a problem.

Many respondents related stories of newcomers who were pressured by various stakeholders to enact the role in a way that best met the needs of the stakeholder. This often led to the newcomer becoming *burnt out and exhausted* and therefore leaving. Most agreed that in order to be successful in the role, the DON/HSM needs to be strong enough to withstand the influence of stakeholders until such times as they can make informed decisions. The difficulty in doing this was readily identified.

What emerges from this is the opinion that those who assume the role should be prepared for it in some way. Very few of the respondents received any type of orientation, formal or informal, and the socialisation into the position was a very erratic process. Where to acquire the skills necessary for the job was identified by the respondents as being problematic. The job requires generalist skills, both in management and clinical practice. Given the degree of specialisation common in metropolitan health services, generalist skills are no longer valued and, apart from rural hospitals, there is probably nowhere that they could be acquired. As one respondent pointed out:

If the job fails it will not be because the idea wasn't a good one, but because there are just not the people around with the right mix of skills to do the job properly.

One respondent echoed the view of many when she indicated that success in the DON/HSM role often related to the qualities and motivation of the individual rather than to preparation and education:

I think it's sort of gutter-survival techniques, really, at the end of the day.

The factors influencing the shaping of the DON/HSM role are summarised in Figure 6.3.

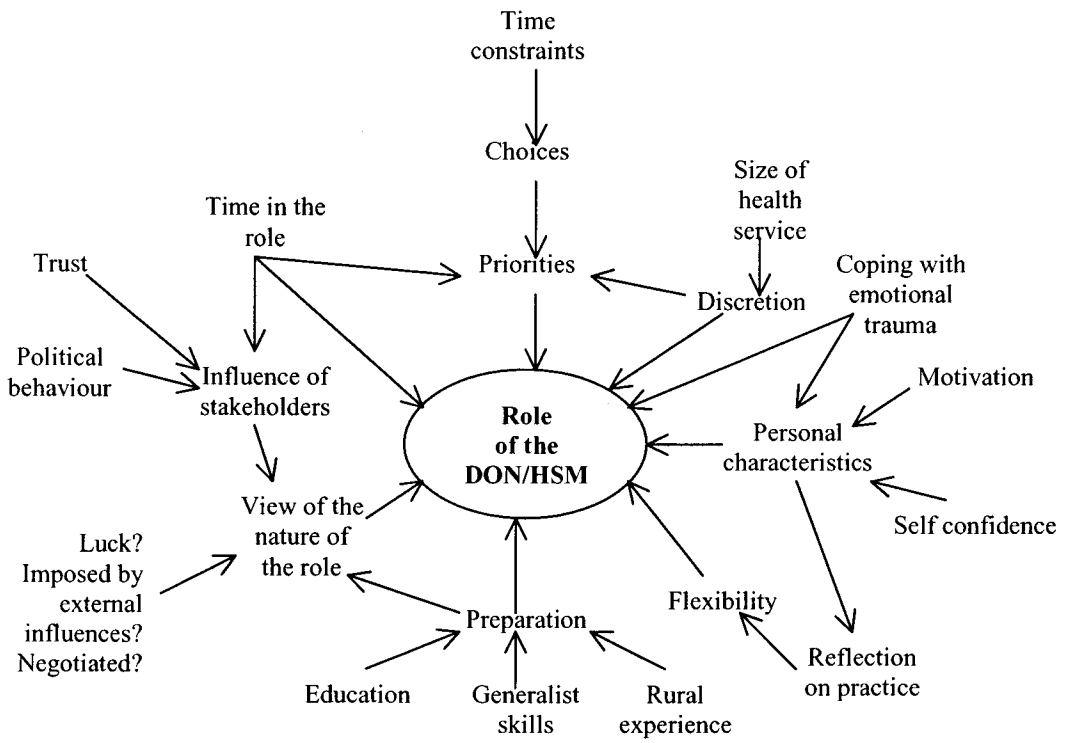

Figure 6.3: Influences on the role of the DON/HSM

6.5.2 Attitudes to the role

The attitudes of the respondents to their role will be reported from two perspectives. First, their personal responses to the experience of the role will be considered. Second, their statements about their commitment to the role as an instrument for the delivery of health care services will be described.

Personal responses to the experience of the role

Despite the problems with the job, a number of the respondents liked the job very much, with some describing it as the best job they had ever had. A typical response for these respondents was: *I love the job. It is a very good job.* Reasons given were that the job provides scope to influence the direction of the health service and a degree of power that would not normally come with any other nursing job. Others expressed their liking with more reservation, with comments like: *It's not that I don't like it. I'm just rung out by it.* There was the opinion that it was *a thankless job*, but it was generally agreed that *you get out of it what you put into it.* Still others reflected the opinion of another respondent: *It's just too hard. It's too difficult.*

This supports the notion that the response of the individual to the role was variable, ranging from embracing the role with enthusiasm to having a desperate need to escape. This variation was summarised by one respondent who reflected on her own experience and her observations of the experiences of others:

> *It makes me really sad because I see a lot of people really struggling and very stressed and actually suffering ... in this work. I could think of five people who just need to get out ... because it's just quietly eating them ... the job is too big.*
>
> *I know another group, another probably ten or twelve, who wouldn't go back to the DONs ever because they've mastered it, and they'd see it as losing face if they had to split the job again. They've actually won.*
>
> *But for myself I've sort of come through ... well I've mastered it. I certainly can do it here, but not in a reasonable time frame. There's not adequate supports ... to enable you to do it in an eight or ten hour day. So why would I be doing it? They're only paying me for 7.6 hours. Why should my job take me twelve?*

Commitment to the role

Notwithstanding the problems inherent in carrying out the role, most of the respondents expressed a commitment to the concept of the role of a clinician manager. A respondent summed up the generally held opinion like so:

> *It's actually one of the most fulfilling roles you could ever find because who better to make a financial judgement than someone with clinical knowledge. And who better to make a clinical judgement than someone who has financial knowledge. But I must admit that that it is not quite so clear how that actually works.*

The notion that clinical expertise was being misused was mentioned by some of the respondents:

> *I often wonder why people like me with loads of clinical experience are not doing what we do best; that is, nursing.*

Most, however, agreed that the alternative, a generic manager was not a reasonable option. The perceived lack of understanding of many of the service delivery issues on the part of the GMs was often cited as support for this point of view. The general opinion was that if there was to be the clinician manager role, it is best to have a nurse in that position as the core business of rural health services is to provide nursing care and *all the other things contribute to that.*

In view of the inherent problems, there was some disagreement about whether or not the role was achievable. Some thought that the concept of a clinician manager was flawed and that there were not enough hours in the day to do the combined role effectively. Most, in contrast, shared the view that the role, although difficult, was not only doable but also essential for getting better decisions for patients. The need for *a better delineation of the role* was a common theme. There was the sense that one of the reasons that the workload of the job was so large was that there the incumbents found difficulties in *letting go* and tried to *do it all.* Most respondents claimed a commitment to the role and considered the job vital for the ongoing development of rural health services.

Commitment to the role appeared to be influenced by the impression that the role was put in place in order to fail. This view was widely held by all those in group 1 and most of those in group 2 — those who were already working in the health care system when the rural health services were restructured and the role of the DON/HSM implemented. The general view was:

They've set us up to fail, but what's happened is we haven't, and they're really cross about it.

Most agreed the GMs, in particular, did not want the clinicians to be able to manage as this made generic managers such as the GMs, redundant. The desire to have the position fail was suggested by some as one of the reasons that those taking the DON/HSM position were given so little support, especially in the transition period. Some expressed the opinion that the idea had been to *put in a generic manager after the DON/HSMs had fallen on their faces, but that didn't happen because nurses are quite resourceful.*

Many of the respondents were able to provide stories of individuals who had not succeeded in the position. There were also examples of some health services that had abandoned the DON/HSM role and reverted to a structure based on the DON and a general administrator. There was the generally held opinion, however, that these failures were more related to circumstances peculiar to the particular health service than the failure of the role per se. Most respondents noted that a high turnover rate of DON/HSMs tended to be in health services where difficulties with certain stakeholders were likely to be a contributing cause. The trouble in attracting high quality applicants to positions in towns considered to be unattractive was also identified as a problem. In such cases, lesser qualified applicants were often appointed to the position and, as such, were less likely to be able to cope with the complexities of the role. This, in turn, further contributed to the high turnover rate.

Most respondents (but by no means all) considered the notion of the clinician manager to be a good innovation, leading to better quality decision making for patient care. An on going commitment to the role by the respondents was a recurrent theme in the interviews. There were, however, frequent comments about the commitment of others to the role. The commitment of the GMs was repeatedly questioned as was that of the GPs who *didn't like their practice scrutinised by nurses.* Given this view point, most respondents expressed a lack of trust in the motives and actions of a number of the stakeholders. There was a sense that the DON/HSM role was enacted in the face of often subversive adversarial pressures. This contributed to the perceived isolation of the role and involved the DON/HSMs in political behaviour in that they would have preferred not to be involved.

6.5.3 Stress and the role

All respondents identified that the role was a considerable source of stress. The general view was that *the job will eat you up.* Views about the high levels of stress inherent in the job ranged from *why do I have to put up with this... I'll probably go* to *I'm not really happy with this, but I'll try and change it* to *I'll learn to live with it.*

The ambiguity of the role and the uncertain outcomes appear to be one of the greatest sources of stress, with the respondents often describing themselves as *the meat in the sandwich* as they are *fairly hammered* by the conflicting demands of the stakeholders. There was the feeling that whoever had the problem, it always ended up being the problem of the DON/HSM. That degree of responsibility was overwhelming for some of the respondents.

Because of the ambiguity of the role and the lack of clear guidelines about the content of the job, many respondents felt conflict within themselves about the way they should best carry out the role. The notion that each incumbent could invent the role at their own discretion and according to their own priorities meant that each had to make personal decisions. Many reported concern regarding whether or not they had made the right choices, particularly in relation to clinical and management responsibilities and which of the stakeholder demands to accommodate. A number suggested that because the job was so busy, it was often easier not to make such decisions but *go with the flow,* reacting to problems and situations as they presented. While some that thought this was the only way to cope with the job, others thought that it only contributed to the vision of the DON/HSM role being *the spinning wheel,* which further contributed to the stress of the job.

Because of the demands of the job, with many respondents reporting working 10–12 hour days plus being on-call, there was an impact on family and other personal relationships. Several of those interviewed attributed their marriage failure to the demands of the DON/HSM role. A number, however, suggested that to have a partner was essential because *you need something to stop you from working all the time.* A few of those interviewed for this research coped with the job whilst having a partner and small children.

Whilst this was acknowledged by other respondents, the general comment was *I have no idea how they do it.*

The need to be on-call was seen to contribute markedly to the stress of the role. All the DON/HSMs were on-call twenty-four hours a day, seven days a week. It was generally agreed that:

> *No one actually knows what it's like to be on-call or the burden of being on-call is unless you've actually experienced it.*

As a number pointed out, it was not necessarily being called that was the stress, but the expectation that a call could come at any time. On-call requirements also had a serious impact on the social life of the respondents as they always had to be in contact with the health service and would have to plan ahead for even a casual visit to the local pub with friends. Some found the demand of on-call more onerous than others did. The number of calls was related to the skills and ability of the staff. In times of staffing shortages, when the DON/HSMs workload would increase, the number of calls also increased. Those who were fortunate enough to have skilled and reliable nursing staff were able to share the on-call times with others. Those DON/HSMs who lived out of town were also called less. On the other hand, there was one DON/HSM who was the only nursing staff member who lived in town and was called frequently. The on-call requirement of the role was seen by some as one of the most onerous parts of the job, and they claimed that the on-call demands would probably be the reason they would leave.

There was a general sense that, in order to survive, every DON/HSM had to learn to manage the stress of the job. It was the view of most, however, that the success of these stress-management techniques was the responsibility of the individual. Although it was recognised that some cope better than others, each person should identify the stressors and put in place supports to help them manage this. While ideal, this is not always easy, as illustrated by the story of a group 3 respondent in a small remote health service.

There's never a day that you can actually say "Okay, today's mine" ... I get in the car and go for a drive ... drive fifty Ks down the road ... music blaring ... escape like that ... out of telephone call range. But you have to do it at a time you know there is not going to be double shifts on. So you can't even go and have your temper tantrum at your convenience.

The idea that the individual brought to the position personal characteristics that made them more able to cope the job was a recurrent theme. The respondents were asked about the personal characteristics needed in order to survive in the job. Generally it was agreed that *you need to be a strong person* with a *high level for self-confidence* and a *deep belief in your ability to do the job.*

The sense was the person who succeeded in the position was one who had the courage of their convictions and could stand up to the stakeholders — the board, the GM and the GP being particularly mentioned. In addition, the individual needed to be strongly motivated to achieve their personal goals and the goals of the health service: *You've got to believe in yourself.*

Factors relating to the stress experienced in the DON/HSM role are summarise in Figure 6.4

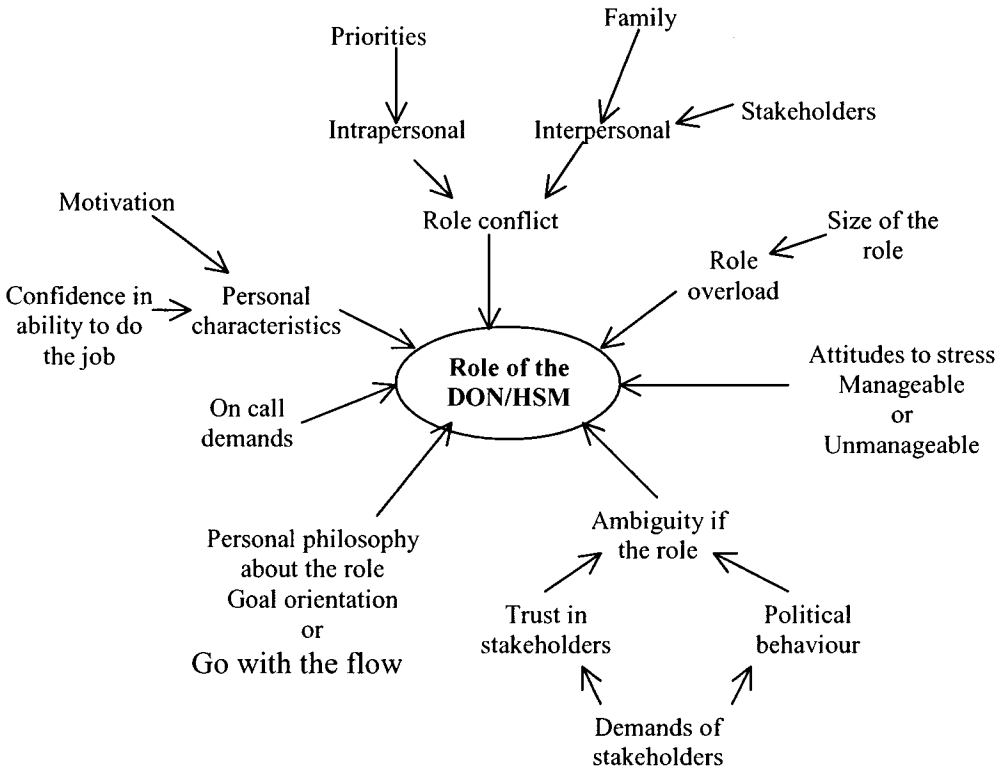

Figure 6.4: Stressors on the role of the DON/HSM

6.5.4 The future of the role

In the view of most of the respondents, the future of the DON/HSM role is in doubt. There is the generally held opinion that the role was introduced as an experiment, and it could be removed in the same way. There is the sense that the role is seriously threatened by the ambitions of the generic managers in the health service. The future, then, for most of the respondents is somewhat uncertain.

Even if the role remains in place, there is some doubt about the direction that their future career may take. A number of the respondents were nearing retirement age and were quite clear that this was to be their last job. Some of the younger respondents, however, were finding themselves in a professional cul-de-sac. Most do not want to move to larger hospitals because the larger hospitals have DON rather than DON/HSM positions. Most view this as a backward step and do not wish to relinquish the general management

component of their job. Only two respondents claimed aspirations to move into a general management position. Apart from the fact that such a move would be largely perceived as "joining the enemy", most did not want to relinquish the clinical component of the role or move out of the direct health service delivery environment.

To move to the metropolitan areas is also seen as problematic. Broadly based rural experience is not considered to be of value in the metropolitan area, where most of the health services are structured around clinical specialities. As one respondent pointed out *DON/HSMs aren't employable anywhere else except in the rural area.* There was the general feeling that:

> *Nobody wants to touch us after we've been here in the bush because there's this fear we don't have enough clinical experience. But we have too much managerial experience to be just on a ward.*

Another respondent who, after two years in a DON/HSM position, unsuccessfully applied for her former Level 3 job in the metropolitan area, supported this view and expressed concern that *I'm never going to be able to get back.*

This lack of career options was seen as a serious problem with consequences for the future of the role. It would be unlikely that the position would attract high quality applicants if taking the job placed future career options in doubt. Without high quality applicants, the position would be more likely to fail, leaving those already in the position in a tenuous situation. Most respondents articulated doubt that the HDWA had any clear vision for the future of the role and expressed a considerable lack of trust in the HDWA to consider their well being in any future policy decisions. The feelings of many of the respondents, particularly those in group 3, was:

> *I have a real identity crisis now because I don't feel I'm an expert in any field ... I don't know where I could fit in any more ... I honestly don't know what I could do if I left this position.*

6.6 Conclusion

The previous two chapters have described the findings from the analysis of the text of the 36 interviews that were conducted to gather data for this research. These findings have been organised in a manner that best explained the data provided by the respondents.

It was recognised that the respondents fell into three distinct groups influenced by the way each came into the job. These groups were

- Group 1 consisted of those respondents who had been the DON of the hospital prior to the restructuring of the rural health services and, following the removal of the hospital administrator, acquired the responsibility for the general management of the hospital and the community nursing services in addition to their clinical role.
- Group 2 consisted of those respondents who had previously had a clinical role in the health service and who moved into the DON/HSM role at various times after its implementation.
- Group 3 consisted of those respondents who had successfully applied for the position from various other nursing jobs — more often than not from areas of practice apart from rural health care.

Irrespective of how they came into the job, job entry was typically characterised by a lack of clear expectations, little orientation and little formal role socialisation. The role was shaped by the influence — and often conflicting demands of — stakeholders, who are defined as patients, health service staff, the health service board, the local general practitioner, the community, the General Manager and the Health Department of Western Australia. Interaction with these stakeholders was mediated by language, identified as being different for each group. The image was of the DON/HSM as the hub of the wheel, spinning constantly under the influence of the stakeholder's expectations. This reinforced the notion that the position was an isolated one and deciding who to trust was difficult. DON/HSMs often resorted to support from a diverse and often informal group because they believed them to be trustworthy.

The balance between the clinical and management components of the role was problematic for all respondents and different criteria were used to establish priorities. These criteria ranged from personal value systems, expertise, confidence and the day-to-day demands of the role. Attitudes to the role varied from some who thought this was the best job they had ever had to those who thought the role was too hard and were quite desperate to escape.

There was general agreement that the role was huge creating high levels of stress. There were mixed views about whether it was achievable or not but there was, nevertheless, the opinion that the clinician manager role led to better patient care decisions.

How the role had developed and how it was interpreted by individuals was influenced by a number of local conditions, and a generalised model of a clinician manager was elusive. The sensemaking process undertaken by the respondents in this research in order to enact the role was, however, moderated by a number of shared influences, suggesting a theory of sensemaking for these clinician managers. This theoretical perspective will be discussed in the next chapter.

Chapter 7: Discussion

7.1 Introduction

The aim of this research was to describe clinician managers' understanding of their role and the adaptation and enactment processes within that role; i.e. their sensemaking processes. The research population, DON/HSMs in rural health services in Western Australia, were investigated as an example of the clinician manager.

The findings of this research suggested that their practice environment influenced the sensemaking of the DON/HSMs. When the rural health services were restructured (see Chapter 2), a loosely coupled system was created. Weick (1976, p. 3) defined "loose coupling" as a situation in which elements are responsive but retain a separateness and identity. The Health Department of Western Australia (HDWA), while remaining the source of funds for the ongoing maintenance of the rural health services, devolved much of the management of these funds to the health service boards. At the same time, the boards became the employer of the General Managers (GMs) and the DON/HSMs of the health services, and the HDWA relinquished any direct role in the day-to-day operational management of the health services. The DON/HSMs were made responsible for the day-to-day operational management of the health services and accountable for health service outcomes. They were answerable to the boards who were to assume a strategic management role and at the same time had a "dotted line" responsibility to the GMs. Some boards embraced their new responsibilities; some did not. The relationship between the GM and the DON/HSM varied markedly from health service to health service, as did the relationship between the board and the GM.

In this way, the rural health services became loosely coupled, with each health service operating as a semi-autonomous unit. Functionally, the organisational structure assumed recognisably different shapes in each health service, which were dependent on local

conditions. In these circumstances, lines of authority and decision-making accountability became muddied. Aghion and Tirole (1997) made the distinction between formal and real authority. Formal authority is considered to be the right to decide, but real authority is the effective control over decisions. In the structure of the rural health services, where this formal authority resided was obscured; and where the real authority resided was variable. This lead to a practice environment characterised by ambiguity and confusion.

As pointed out by Spender and Grinyer (1995), however, loose coupling implies that there is some source of organisational cohesion other than administrative structure. They argued that such organisations are held together by internal "institutional" forces and activities. There is support for this point of view in the rural health system, where two elements of cohesion could be identified. One element was the legal requirements. Practice in health services is constrained by a series of Acts (for example the *Nurses Act* and the *Hospitals Act*) as well as by the prescriptive documentation and reporting requirements necessary for the HDWA, as a government department, to report to Parliament. Compliance with the Acts and accurate completion of reporting requirements was an obligation for every health service. The other element of cohesion in the rural health system was the clear function of each health service; i.e. to meet the health care service of the local community. The ambiguity lay in how these services would be delivered and how the priorities were established.

The nature of ambiguity is described by Weick (1976, p. 3.) using the metaphor of a soccer game:

> Imagine that you are either the referee, coach, player or spectator at an unconventional soccer match: the field for the game is round; there are several goals scattered haphazardly around the circular field, people can enter and leave the game whenever they want; they can say "that's my goal" whenever they want to, as many times as they want to, and for as many goals as they want to; the entire game takes place on a sloped field, and the game is played as if it makes sense.

This suggests that in organisations characterised by ambiguity, or as Weick (2001) prefers, "under-organised systems", goal setting is haphazard, with participation in the decision-making process uncertain and influenced by the personal preferences of the participants and other uncontrollable and unpredictable external forces. The respective degree of influence of the goals of the organisation and that of individuals is uncertain. This was the situation in the rural health services. The DON/HSMs revealed that they had to cope with adaptation to a new, poorly understood role in and environment of ambiguity. The period of adaptation was characterised by a failure in sensemaking and had characteristics of a crisis situation.

The notion that underpins sensemaking is that reality is an ongoing accomplishment that emerges from efforts to create order and make retrospective sense of what occurs, emphasising that people try to make things rationally accountable to themselves and others (Weick, 2001). Crises are characterised by low probability but high consequence events that resist interpretation and impose severe demands on sensemaking. Schemas, the mental maps that guide the search for and acquisition of information, were no longer appropriate. The new organisational structure and the role of the DON/HSM within that structure left large gaps in the schemas developed on the basis of previous experience. The DON/HSM were required to "fill in" information, uncertain whether or not they had made correct assumptions about the situation. Despite this doubt, the DON/HSMs had to take action; patients continued to present to the health service, and reporting requirements still needed to be met. To take action was also a function of their sensemaking processes, a case of "learning by doing". In taking action, the DON/HSMs themselves brought events and structures into existence, simultaneously generating circumstances that affected the situation itself. In this way, some of the ambiguity was enacted by the DON/HSM themselves.

It emerged from the analysis of the interviews conducted for this research that the sensemaking process of the DON/HSM was impacted upon by a number of influences. Drawing from the findings reported in the previous chapters, a substantive theory (Strauss and Corbin, 1990) was developed that best explained the sensemaking and enactment of the

DON/HSM role. A model of the theory is represented in Figure 7.1. This chapter will explain this theory in terms of the research findings and the research literature and discuss directions for future research.

7.2 Overview of the model

The structure in which the DON/HSM role is enacted extends beyond that of the formal organisational structure defined by the HDWA and embraces all of those who can be considered stakeholders in the role. Adapting the definition of stakeholders offered by Blair and Whitehead (1988), who focused on the organisational level, stakeholders in the context of this research are defined as those individuals and groups who rely on the DON/HSM for the achievement of their goals but who, in turn, the DON/HSM relies upon for their support and cooperation.

Seven stakeholders, considered most relevant to the DON/HSM role have been identified in this research. They are HDWA, GMs, the local community, GPs, the health service board, health service staff and the patients of the health service. The stakeholders may be considered internal to the health service (for example the health service staff and the patients), external to the health service but internal to the larger health service system under the auspices of the HDWA (for example, the HDWA itself and the GMs), external to the health service (for example the local community) and those in unique and somewhat ambiguous boundary spanning positions such as the health service board and the GPs.

The sensemaking process of the DON/HSM is mediated by their interaction with the stakeholders. The factors identified as being most influential in this process were the DON/HSMs' perceptions of the trustworthiness of the stakeholders, the political behaviour that characterised the interactions and the role stress — particularly role conflict, role ambiguity and role strain.

The sensemaking of the DON/HSM is further mediated by personal characteristics of the DON/HSM. The most salient personal characteristics are the way in which they experience and cope with the role strain, self-efficacy (their belief in their ability to do the job) and

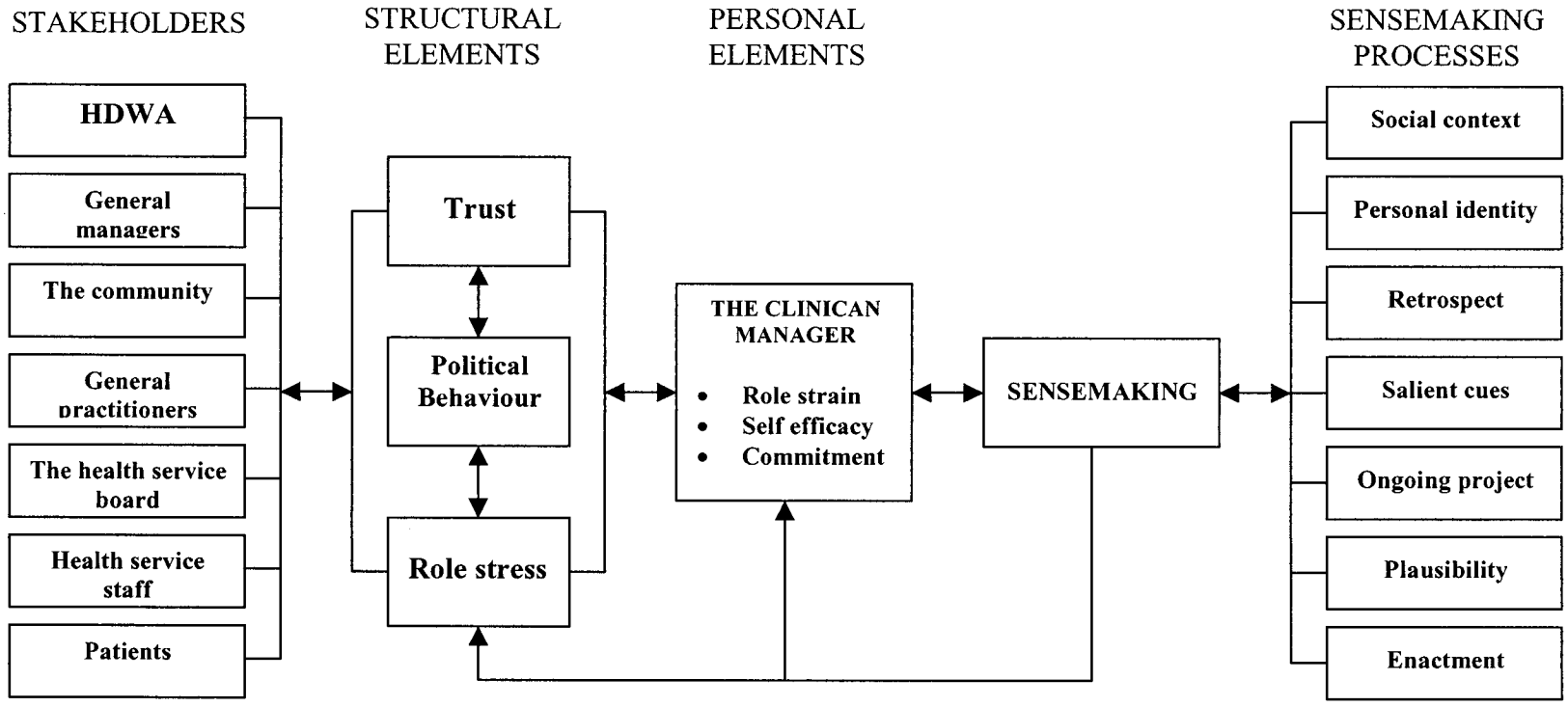

Figure 7.1: The DON/HSM as clinician manager: a model of the sensemaking process

their commitment to the sensemaking process. These influences interact to mediate the sensemaking process (Weick, 1995). Sensemaking is proposed to have seven properties: social context, personal identity, retrospect, salient cues, ongoing project, plausibility and enactment (Weick, 2001). The sensemaking of the DON/HSM in the clinician manager role, in turn, impacts on the interaction with the stakeholders in an interactive and ongoing cycle. Each of these elements will be discussed in more detail in this chapter.

7.3 The DON/HSM as clinician manager: structural elements of the sensemaking process

Drawing from the proposed model, this section discusses the structural elements that mediate the sensemaking processes of the DON/HSM in their role as clinician manager: trust, political behaviour and role stress.

7.3.1 Trust

Trust was a recurrent theme in the interviews conducted for this research, with the respondents mentioning trust as an issue in the relationship with all of the stakeholders. Given the uncertainty and ambiguity that is characteristic of the interactions between the DON/HSM and the stakeholders, for those relationships to be effective in organisational terms there must be trust in them. Similarly, trust is required if the interrelated and interdependent nature of the stakeholder relationship is to lead to mutually agreed goals. It is proposed that the level of trust the DON/HSM has in the individual stakeholders will influence interaction, communication and, hence, sensemaking. This section provides a brief overview of trust as a theoretical construct and then discusses the trust relationship between the DON/HSM and the identified stakeholder.

Theoretical perspectives

The view of trust as a foundation for social order has received considerable attention in the literature and spans many intellectual disciplines and levels of analysis (Lewicki, McAllister and Bies, 1998). It has been suggested (Bigley and Pearce, 1998) that the research on trust could be grouped into three primary categories. Each category is associated with a particular disciplinary perspective: (1) personality theorists' view of trust as an individual difference, (2) sociologists' and economists' notions of trust as an

institutional phenomenon and (3) social psychologists' conceptualisation of trust as a expectation of another party in transactions. It is this third perspective that best explains the findings of this research.

The social–psychological perspective reflects the notion that trust may be defined as one's belief in and willingness to depend on another party (McKnight, Cummings and Chervany, 1998). Trust is seen as a confidence that no party to an exchange will exploit the other's vulnerability (Sabel, 1993). The concept of vulnerability recurs frequently in the trust literature, with some viewing trust as a willingness to be vulnerable (Mayer, Davis and Schoorman, 1995). This suggests that trust involves situations where at least one party has something meaningful at stake and is cognisant of the potential betrayal and harm from another. From this perspective, vulnerability is only salient after harm has been caused. If one was invulnerable, trust in others would not be an issue. Nevertheless, an individual's perception of their own vulnerability is likely to influence their levels of trust. This introduces the notions of trust and distrust.

Lewicki et al. (1998) reported that traditionally, trust has been viewed as good and distrust as bad, and as such, at opposite ends of a unidimensional continuum. This perspective of trust is supported by Jones and George (1998), who proposed an interactionist model in which there are three distinct forms of the trust experience: distrust, conditional trust and unconditional trust. They viewed these as three different states of the same construct. Lewicki et al. (1998) took another view, however, and suggested that trust be defined in terms of confident positive expectations regarding another's conduct and distrust as confident negative expectations of another's conduct. In this way trust and distrust are understood as separate but linked constructs and it is therefore possible for parties to both trust and distrust one another in different facets of their relationships. This supported the position taken by Sitkin and Roth (1993), who also conceptualised trust and distrust as separate constructs, each with a different set of determinants. Trust was determined by met expectations; whereas, distrust was determined by value incongruence.

A frequent theme in the trust literature has been that of "building trust". This implies that trust (and presumably distrust) grows over time, and suggests that trust levels begin low and gradually increase. McKnight et al. (1998), following a review of the empirical research, found inconsistent support for this proposition, leading them to describe the "paradox of high initial trust levels". They reported that in both survey and experimental studies, subjects had high initial trust levels in situations when parties first meet or interact. This initial trust may be fragile or robust, and it was proposed that it has two dimensions: trusting intentions — meaning that one is willing to depend on the other person in a given situation — and trusting beliefs: meaning that one believes the other person is benevolent, competent, honest or predictable in a situation. This proposal supported that of McAllister (1995) who suggested that trust has both cognitive and affective elements. The cognition-based component of trust is a choice founded in knowledge of the other party and presumed "good reasons" for trust. The affective foundations of trust are founded in the emotional bonds between individuals. It is proposed that the affective-based trust is more robust, and that affect often persists after complete invalidation of its original cognitive base.

Jones and George (1998), however, suggested that in the initial interaction between two parties, the individual simply suspends belief that the other is not trustworthy and behaves as if the other has similar values and can be trusted. In the face of no evidence to the contrary, a provisional assumption of trustworthiness is made. One accumulates trust-related knowledge through experience with the other person (McKnight et al., 1998) and then one makes decisions, or reviews previous decisions, based on that experience.

Decisions about the trustworthiness of the other party are made on the basis of the individual's perception of shared values and attitudes to the other's behaviour in interactions, both with self and others. These interactions are interpreted in the light of previous experience. Trust decisions are also influenced by moods and emotions, which further supports the notion of both a cognitive and affective element of trust. Thus people approach interactions based on their own orienting values and make judgements about the trustworthiness of the other based on those values. In this way trust may or may not

develop in the first place, or trust may dissolve when expectations are not reciprocated. Dissolution of trust may be understood as betrayal.

Betrayal occurs when personal expectations of an individual are violated by a specific other party (Elangovan and Shapiro, 1998). These violations many be intentional or unintentional, voluntary or involuntary. When personal trust is broken there can be significant negative personal consequences and possible implications for the organisation, as relationships important for the achievement of organisational goals become increasingly problematic. The other party in the betrayal may be an individual or, as Morrison and Robinson (1997) suggested, it may be the employing organisation with whom the individual has a psychological contract. These writers proposed that psychological contracts are made up of employees' beliefs about the reciprocal obligations between themselves and the organisation and reflect a degree of trust in the organisation. This trust, however, may be violated when the employee believes that the organisation has failed to fulfil one or more of these obligations, resulting of feelings of anger and betrayal.

The trust relationship: the DON/HSM and the stakeholders

The findings of this research suggested that individual personalities had a significant impact on relationships with stakeholders. The trust experience of the individual DON/HSMs was influenced considerably by personal relationships with individuals because in small rural communities there may be only one member of a particular stakeholder group. For example, if the DON/HSM experienced a personality clash with the only GP in town, this may impact significantly on their trust relationship. In larger health services with a number of GPs, such a personality clash with one individual may not affect the combined trust relationship with the stakeholder group as a whole.

It was also observed that the groups of DON/HSMs identified in this research experienced the trust relationships in different ways. Those in group 1, who were familiar with the stakeholders prior to the adoption of the DON/HSM role, had to a certain extent, already made trust decisions when they took over the role. Those in group 2 were more uncertain. They were familiar with the local stakeholders but were uncertain of the degree of trust they could place in other stakeholders such as the HDWA and the GMs. Those in group 3

had little prior knowledge on which to draw and were required to make trust decisions concurrent with their sensemaking in the new position. There was evidence, however, of the "paradox of high initial trust levels". (See the previous discussion.) Most respondents in this group viewed stakeholders as trustworthy until proved otherwise. A number expressed distress, anger and disappointment that those they trusted without question, betrayed that trust.

The following discussion will focus on the aggregate views of those interviewed, while accepting that the experience of each individual may differ.

The Health Department of Western Australia

Most respondents expressed varying degrees of distrust in the HDWA. It was generally agreed that HDWA policies and decisions did not reflect an understanding of rural health services or the role of the DON/HSM, and for this reason, the HDWA frequently did not meet the DON/HSMs' expectations for support.

Many of the respondents in this research gave examples of incidents where they considered that they had been betrayed by the HDWA in the resolution of conflict with other stakeholders. That the HDWA was seen as implementing the role of the DON/HSM in order for it to fail, thus demonstrating the inability of clinicians to be responsible for general management, was a widely held belief. Most expressed little confidence that should the DON/HSM role be abandoned, the HDWA would acknowledge their efforts in the role or provide alternative career directions. Many respondents cited examples of contradictory or conflicting information provided to them by the HDWA, which further eroded their trust.

General Managers

Almost without exception, the respondents expressed distrust in the GMs. Most believed that the GMs could not be trusted to act in a way that the DON/HSMs considered to be in their best interests. Many reported avoiding interaction with the GM whenever possible.

The community

The trust relationship with the community was most problematic with those in group 3. Those in groups 1 and 2 considered themselves as part of the community and saw their relationship in quite different terms. They trusted in the community to support the health service with such things as fundraising for special projects. A number of group 3 respondents, however, expressed the concern that if they established too many personal relationships in the community; the time would come when those party to those relationships would have unrealistic expectations of the DON/HSM and of the health service.

General practitioners

The trust relationship with the GP offered support for the notion that trust and distrust may be understood as separate but linked dimensions, with many DON/HSMs reporting both trust and distrust in different facets of this relationships. Some respondents, for example, trusted the GPs' clinical abilities, but distrusted the GPs' practice in terms of acting in the best interests of the role of the DON/HSM, who as part of their role, were accountable for the budget of the health service. The GPs did not generally share the financial concerns, although their practice had considerable impact on health service costs. In some cases (although not all) this conflict led to the DON/HSM having a considerable distrust in the GP.

The health service board

The trust relationship with the health service board was variable and often depended on personalities and the board's interpretation of their own role. Some of the respondents reported a positive relationship with the board and believed they could trust the board to provide support when needed. Others found the relationship with the board was characterised by suspicion and a lack of trust.

Health service staff

Those respondents in group 3, particularly, found that the trust relationship with the health service staff was difficult. Many found that when they assumed the role, the staff were very

suspicious and showed very little trust in the DON/HSM role in general and them in particular. Establishing a trust relationship with the staff was often identified by these group 3 respondents as one of their most important priorities but at the same time one of the most demanding parts of their role. Concomitantly, the respondents found that trusting the staff to support them in their role was often difficult. When trying to implement organisational change and changes in clinical practice, both active and passive resistance to change was a common experience.

Patients

The trust relationship with the patients took a different direction. The issue was not the trust that the DON/HSMs had in the patients so much as the patients' trust in the health service to provide high quality health care. As such, this relationship did not impact on the levels of trust held by the respondents in the way that the relationships with the other stakeholders did.

The levels of trust revealed by the respondents in relation to the stakeholders is summarised in Table 7.1. In this table trust is reported as a linear construct ranging from low (LT) to undecided (UT) to high (HT). The degree of certainty related to the respondents' confidence in their assumptions of trust ranges from low (LC) to undecided (UC) to high (HC). It was recognised that there was considerable variation amongst the respondents regarding their assumptions about their trust relationships, especially in relation to some stakeholders such as the GP and the health service board. This table thus represents an aggregate view.

Table 7.1: Assumptions of trust and certainty

Stakeholder	Group 1	Group 2	Group 3
HDWA	LT, HC	UT, UC	HT, UC
GM	LT, HC	LT, HC	UT, UC
Community	HT, HC	HT, HC	UT, UC
GP	UT, HC	UT, HC	UT, HC
Board	HT, HC	UT, UC	LT, UC
Staff	HT, HC	HT, UC	LT, UC

Those respondents in group 1 were much more certain about the nature of their trust relationships than the other groups. Group 3, particularly, experienced indecision and uncertainty in many of their trust relationships.

Discussion

The perceptions of the respondents regarding their trust relationships with the stakeholders were characterised by high levels of distrust. These levels of distrust developed over time based on experience. The distrust had both cognitive and affective elements. The cognitive elements followed a rational decision-making process based on events when, in the perception of the respondents, the other parties' levels of trustworthiness was demonstrated. The affective element of trust was based on personal liking of the other person, often a significant influence in a small rural community.

Most respondents expressed a need to be able to trust the stakeholders if the DON/HSM role was to be developed, and expressed feelings of betrayal that is was apparent that their confidence in the trustworthiness of many of the stakeholders was misplaced. That the respondents could trust some stakeholders in some areas of their interaction but not others suggests that, in this case, trust and distrust may be two different constructs. Many respondents expressed distress that they did not know who to trust and often turned to others external to the formal structure of the health service for support.

Sensemaking is influenced by the actual, implied or imagined presence of others; and sensible meanings tend to be for those for which there is social support, consensual validation and shared relevance (Weick, 2001). In the sensemaking process, people strive for stability and predictability and look to their interactions with others for behavioural confirmation of their beliefs and expectations. As pointed out by Weick (1995), however, faith is instrumental to sensemaking. When the relationship with social anchors is threatened by a lack of trust, the understanding of what is happening becomes less certain. With the failure of trustworthy reference points, there is a need to resort to conversations with oneself and subjective interpretations in the light of personal schemas. As personal schemas are developed following previous experience, schemas in new and novel situations are likely to be inaccurate and incomplete. The new DON/HSMs therefore often found themselves in the unfortunate position of having uncertain trust in their interactions with others and uncertain trust in their personal schemas — both of which significantly impacted on their sensemaking.

7.3.2 Political behaviour

Associated with and impacting upon the trust relationships between the DON/HSMs and the stakeholders was the political behaviour that was reported. The influence of political behaviour on the sensemaking process has been largely overlooked in the literature, but in this research it was found to be an important influence on the sensemaking process of the respondents.

The restructuring of the rural health services, with the blurring of the lines of authority encouraged the stakeholders to pursue personal power bases in order to promote their own goals. Significant reconfigurations of organisations invariably trigger conflict and resistance, both overt and covert, motivated by a blend of organisational concern and self-interest (O'Byrne and Leavy, 1997). For this reason, change and uncertainty can heighten the intensity of political behaviour.

Theoretical perspectives on political behaviour

Power is conventionally defined as the capacity of individuals to exert their will over others, and politics is the practical domain of power in action (Buchanan and Badham, 1999). Political behaviour, then, are the strategies and techniques used to exert that influence. There is considerable debate in the literature about the nature of political behaviour in organisations — with political actions often being described in terms of those actions that fall outside the legitimated structure and, hence, threaten organisational goals (Clegg and Hardy, 1996b). For example, Mayes and Allen (1977, p. 675) defined organisational politics as the "management of influence to obtain ends not sanctioned by the organisation or to obtain sanctioned ends through non-sanctioned means".

Further to this conceptualisation of political behaviour as that which is not sanctioned by the organisation has been the notion of power being "good" or "bad". This had led to the distinction between positive and negative uses of power as illustrated by the Greiner and Schein (1988, p. 23). These writers contrasted the "high road" — in which power brokers are led to deploy their resources and tactics in ways that are "open and above board" — with the "low road" — where deceit, manipulation and "political games" are used to further self-interest. It has further led to the distinction between formally prescribed power — the authority to influence based on the organisational position — and "actual" power, that used by others that was seen as informal and therefore illegitimate (Clegg and Hardy, 1996b). This has parallels with the notion of formal and real authority suggested by Aghion and Tirole (1997) where formal authority is considered to be the right to decide, but real authority is the effective control over decisions. (See the previous discussion.)

As pointed out by Buchanan and Badham (1999), there has been a tendency for organisational theorists to deny, repress or neglect the political dimension of organisational functioning. Although many theorists, for example Mintzberg (1983), see the need to eradicate politics, it is now widely recognised that power and politics are a significant feature of organisational life (O'Byrne and Leavy, 1997). The flattening of organisations' structures, as with the restructuring of the rural health services, has given greater autonomy

at all organisational levels, creating more power sources and more sophisticated politics within organisations (Handy, 1992).

Discussion

In this research the respondents reported political behaviour on the part of all the stakeholders. It is proposed that each of the stakeholders have different needs of the health service and tried to influence the DON/HSM to make their particular interests a priority. In broad terms, the priorities of the stakeholders are summarised in

Table 7.2.

Table 7.2: Stakeholders' priorities

Stakeholder	Priorities
Health Department of WA	A health service that: • remains within budget; • meets legal requirements; and • manages risk effectively.
General managers	• Maintain a personal position of control within the health service. • Ensure that the health service remains within budget.
The community	• Maintain a health service in the town. • Keep a general practitioner in the town.
General practitioners	• Maintain their clinical autonomy in their practice of medicine. • Have access to the facilities of the health service when required. • Maintain their personal income.
The health service board	• Ensure the health service reflects the status of the town. • Ensure that the health service provides the services perceived as necessary by the community. • Ensure that the health service remains within budget.
Health service staff	• Maintain employment in the health service. • Have control over their inputs to the health service.

Patients	• Have health care needs met efficiently and effectively.

Although all stakeholders essentially wanted the same thing, good quality patient care, their priorities in meeting that outcome showed some distinct differences. Political behaviour, in an attempt to influence the decision making of the DON/HSMs in the establishment of priorities was a feature of health services in all districts. The types of political behaviour described by the respondents were diverse and are summarised in Table 7.3. The examples offered are not definitive but are a representative of the behaviours reported.

Table 7.3: Political behaviours experienced by DON/HSMs

Political behaviour	**Examples offered by the respondents**
Gate keeping of information	GMs did not pass on information from the HDWA to the DON/HSM.
The formation of coalitions	The GM *did deals* with the GP and/or the health service board without informing the DON/HSM.
Reporting differences of opinions to the media	The GP took complaints about the DON/HSM directly to the local media without discussing the matter first. The DON/HSM found out about the conflict when given the newspaper by a hospital cleaner.
Calling of community meetings	Meetings were called by community members, leading to an en masse march to the health service to protest the DON/HSMs decision regarding the GPs access to the facilities of the health service.
Active resistance to change initiatives	Nursing staff in the health service refused to change practice at the request of the DON/HSM despite research evidence.
Appeals to higher authorities	GPs taking complaints directly to the Chief Medical Officer in the HDWA, not informing and by- passing the DON/HSM, the health service board and the GM.
The use of language, such as "medical" language and "management" language to exclude those who did not speak the language from the discussion.	The GP using medical language when approaching the GM for special funds for new equipment.

Most writers agree that the use of power and politics in organisations occurs most frequently in situations when goals are in conflict, where power is diffused through the organisation, where information in ambiguous, where cause and effect relationships between actions and outcomes are unknown or uncertain, and when resources are critical and scarce (Alexander, 2000). Why some groups, such as departments, professional groups, special interest groups and the like exert more influence on organisational decision making than others can be explained in terms of strategic contingencies theory (Hickson et al., 1971). Viewed from this perspective, organisations are seen as interdepartmental systems, and the division of labour becomes the ultimate source of power. Power, and hence the ability to influence the decision-making process, is explained by the tasks and functions of each subunit and by its links to other subunits. The organisation is considered to face critical or strategic contingencies; i.e. influences from its operating environment that must be managed in order for the organisation to achieve its expressed goals. The group or subunit that copes with these strategic contingencies in the most effective manner controls intraorganisational group power. Coping confers power by creating dependencies.

Although the DON/HSM described political behaviour in terms of the actions of other stakeholders, the strategic contingency perspective illustrates the power bases that the DON/HSMs have. These sources of power are described below.

Coping with uncertainty

By stopping uncertainty from arising, by forecasting an event so that responses can be planned, and by dealing with uncertainly when it eventuates, one group may give other groups a sense of confidence that somebody, at least, is in control. This promotes a dependence on the group that is seemingly in control. The DON/HSM in their pivotal position and their role in the operational management of the health service have coping with uncertainty as one of the key functions of their role.

Centrality

Centrality is a product of the pervasiveness of a department's links with other subunits and the importance of its activities to the work flow of other units. The pivotal role of the

DON/HSM means that they are the only group that has contact with all of the other stakeholders.

Substitutability

Substitutability is the extent to which a unit's activity can be replaced by another group. This is one area where the power base of the DON/HSM is not as certain. Despite the fact the health services can and do operate in the absence of a resident GP, the community and the health service board believe that a GP has more importance than a DON/HSM. Much of the political behaviour reported gave examples of health service boards and community groups forming coalitions with the GP in order to challenge the authority of the DON/HSM. In addition, legally many of the functions of the health service cannot be performed without the presence or the written permission of a medical practitioner. In this way, the substitutability of the GP far is far less than that of the DON/HSM. Furthermore, the GMs seem to believe that they themselves should substitute for the DON/HSM.

The strategic-contingencies approach to power has been investigated in health service organisations and general support has been found for it. See, for example, Cohen and Lachman (1988) and Fried (1988). A group that can buffer other groups from uncertainty whilst being sufficiently central and nonsubstitutable can widely influence decisions beyond their competence and legitimate authority. The DON/HSM has an advantage in two of the three areas.

Political behaviour was deployed simultaneously in the pursuit of and defence of organisational goals as well as for personal and career objectives. Many of the respondents reported some discomfort with the political nature of the their role and the political behaviour in which they became embroiled. This was consistent with Prideaux (1993) who found than in the transition from a clinical role to the management role, the political character of organisations presented one of the most difficult challenges. Clinical practice, with well understood tasks, clear authority and a patient focus did not prepare the DON/HSM for the unpredictability and ambiguity of the political environment in which they were now expected to operate. Many still seemed to take the view that political behaviour was "unpleasant".

Viewing power and hence political behaviour as straightforward dichotomies between "legitimate" and "illegitimate", "sanctioned" or "unsanctioned", "altruistic" or "self-serving", "good" or "bad" do not appear to serve any purpose in the context of this discussion. Of more significance is that political behaviour was pervasive, reported by all the respondents and, as such, was a reality in the every-day practice environment of the DON/HSM. Of interest is how this behaviour impacted on the sensemaking processes of the DON/HSM in their role of clinician manager.

When discussing the influence of stakeholder power in health service organisations, Daake and Anthony (2000) observed that since managers cannot pay attention to everything or every group equally, they must operate in a bounded-rationality framework. As a result, managers tend to consciously or unconsciously make decisions about the relative power of stakeholders and make decisions about the relative importance of priority demands. The sensemaking process responds to extracted cues from the environment. Extracted cues are the seeds from which people develop a larger sense of what may be occurring; i.e. points of reference that direct attention (Weick, 1995). Sensemaking is the interpretation and the activity of determining what the noticed cues mean. When events are noticed, people make sense of them. If events are not noticed, they are not available for sensemaking. This implies that people scan their environment in search of salient cues.

Starbuck and Milliken (1988) argued that this is not necessarily the case and made the distinction between noticing and scanning. Scanning has connotations of a more conscious and deliberate process that is less open to invention. Noticing, on the other hand, describes the more informal and involuntary beginning step in sensemaking. Fiske and Taylor (1991, p. 265), following a review of the social cognition literature, concluded that things that are noticed are "things that are novel or perceptually figural in context, people or behaviours that are unusual or unexpected, behaviours that are extreme and (sometimes) negative".

Political behaviour leads to different interpretations of events. The aim of political behaviour is to make one party's interpretation generally accepted as the "right"

interpretation. In this way, the political behaviour of others may result in the DON/HSM noticing and focusing attention on the particular issues of concern and not noticing others. As events not noticed are not available for sensemaking, political behaviour can serve to constrain sensemaking. Political behaviour can also affect the trust relationship, as the parties involved question the motives and actions of the other.

In this way, the issues of trust and political behaviour are interrelated and interdependent, with one affecting the other and both affecting the sensemaking of the DON/HSMs.

7.3.3 Role stress

The data suggested that varying degrees of role stress, the stress caused by the organisational structure and job design, was experienced by all of the respondents.

Theoretical perspectives

Conceptually, a role is a pattern of behaviours perceived by an employee as behaviours that are expected (Ilgen and Hollenbeck, 1991). Although role expectations may seem to refer to a set of job tasks, the literature distinguishes between job tasks and roles with the latter being the set of expected behaviours engaged in while performing the job tasks. Role behaviours, therefore, can include expectations not necessarily engaged in while performing the job tasks (Tubre and Collins, 2000). In this way, role stress may be a feature of the behavioural expectations of the role.

Role stress is located in the organisational structure, and as such, its source is external to the individual (Hardy and Hardy, 1988). Due to the design of the organisational structure and the design of the job within that structure, situations may arise where role obligations are vague, difficult, conflicting or impossible to meet. Role stress is a characteristic of the social system, not the person in the system. The antecedents of role stress have been described variously, but may be generally summarised in a role stress typology. Hardy and Hardy suggested (1988) a typology that was generated following an analysis of research into role occupants who were encountering major difficulties in meeting their role obligations. The classes in this typology are summarised in Table 7.4.

Table 7.4: Typology of role stress (Hardy and Hardy, 1988)

Classes of role stress	Description
Role ambiguity	Vagueness, lack of clarity of role expectations
Role conflict	The simultaneous occurrence of two or more role demands such meeting one would preclude meeting the other
Role incongruity	Self-identity and subjective values are grossly incompatible with role expectations
Role overload	Having to many role demands and too little time to fulfil them
Role underload	Role expectations are minimal and under utilise the abilities of the role occupant
Role over-qualification	Role occupant's motivation, skills and knowledge far exceeds those required
Role under-qualification (role incompetence)	Role occupants lack the necessary resources (skills, knowledge and abilities) too meet the demands of the role.

Flynn (1998) argued that some degree of role stress occurs as new roles are established, but this can be managed with well developed formal and informal socialisation practices and open communication channels within the organisation. The onus is on the organisation to design organisational structures and jobs within those structures that limit role stress. The onus is also on the organisation to put in place good human-resource-management practices that match the skills, knowledge and abilities of the individual with the demands of the job. The need is for the organisation to manage role stress as it has consequences for the job incumbent and consequently the organisation. Tubre and Collins (2000), following a meta-analysis, reported negative relationships between role strain constructs and job performance.

Those assuming a new role learn of the expectations of their role behaviour in a process of socialisation. King and Sethi (1998, p.197) described socialisation as the activity that

confronts and lends structure to the entry of non-members into an already existing world or sector of that world. The notion of socialisation was applied to an organisational setting by Van Maanen and Schein (1979, p. 210) and defined as "the fashion in which an individual is taught and learns what behaviours and perspectives are customary and desirable within a work setting as well as what ones are not". Van Manaan and Schein suggested linkages between socialisation tactics and the resulting behavioural response: the role orientation. It was posited that while socialisation tactics have a strong impact on newcomers, it also impacts on existing members who are experiencing role transitions or crossing organisational boundaries. Similarly, different methods of socialisation would result in varying role responses.

Formal socialisation tactics include orientation sessions, internal publications, job and career workshops, mentoring and presentations by senior management. The aim is to provide information that reduces the uncertainty and anxiety inherent in early work experiences (Ashforth, Saks and Lee, 1998). Individualised socialisation on the other hand, is informal and variable, encouraging new comers to question the status quo and develop their own approaches to their roles. In a study on the impact of socialisation on role adjustment, Jones (1986) found that institutionalised and individualised socialisation tactics have different effects on newcomers' roles and personal adjustments to their organisations, and that organisations can structure their socialisation practices to encourage desired responses in new employees.

Like all organisational members, newcomers are motivated to reduce their uncertainty, creating a work environment that is more predictable, understandable and controllable. Uncertainty is reduced through the information that is provided via various communication channels; for example, social interactions with superiors and peers. Formalised socialisation programs may influence newcomers' adjustment to the organisations by reducing their high levels of uncertainty and anxiety. The relationship between entry training, levels of anxiety and work outcomes has been demonstrated by a number of workers. See, for example, Saks (1996).

The socialisation processes for newcomers to an organisation or for those undertaking new roles provide a social context in which sensemaking is facilitated. The orientation process provides salient cues that the newcomer uses to interpret the expectations of the organisation and what is important in their understanding of their new job. Actions taken by the newcomer are then compared with the expectations communicated in the socialisation process. In this enactment stage of sensemaking, individuals may alter their job in subtle ways as they cope with unexpected or surprising cues, but this is usually done in the framework of organisational expectations. Formalised socialisation processes in organisations are designed to communicate organisational expectations in a clear, understandable manner. Informal socialisation facilitates the sensemaking of the newcomers in a much less structured manner, with the noticing of cues becoming a much more subjective process.

Discussion

Most of the respondents in this research reported a total lack of any formal socialisation process. The socialisation they received to their new role could be best described as informal, indiscriminate and unreliable. There was marked differences between districts, depending on the General Managers' and the health service boards' interpretation of their own role responsibilities. As a number of the respondents pointed out, as nobody knew what the role was meant to look like orientation and socialisation processes had to be, at best, vague. Most of the DON/HSMs managed their own socialisation processes, both consciously and unconsciously, by pursuing information on a need-to-know basis and making decisions about whose information was trustworthy. Many, who had no previous experience on which to draw, made these decisions based on intuition or "gut feeling". In this way, the organisation had little premeditated control over the sensemaking process of the DON/HSMs.

When designing a job, the organisation needs to give attention to the role stress inherent in that design. The positive relationship between elements of role stress and role performance makes this a concern for the management of any organisation. Role stress, however, was an inherent part of the role and reported by all respondents. Examples of the role stress

reported have been classified according to the role stress typology of Hardy (1988) and are summarised in Table 7.5.

Table 7.5: Examples of role stress

Role Stress	Reported example
Role ambiguity	Role expectations were unclear. Most respondents felt that none of the stakeholders had a clear understanding of the role or were able to communicate expectations in a logical or coherent way.
Role conflict	Each of the stakeholders had different expectations of the role and these expectations were often contradictory and mutually exclusive. Most of the conflict lay in the demands for the management and for the clinical components of the role.
Role incongruity	A number of respondents expressed the opinion that they did not want to do the job or that they only intended doing it for a short time. To be at the focus of the conflicting demands and political behaviour of the stakeholders was not what they saw as their professional future. Many did not wish to relinquish their clinical practice to the degree demanded by the job.
Role overload	All respondents commented at length on the excessive demands of the role, that there was too much to do in the inroads the job demands made on their personal life. Many questioned whether or not the role was "doable" and how long an individual could maintain the workload.
Role underload	Most of the respondents' comments related to the best use of their skills. Some with advanced clinical skills considered these were being under-utilised.
Role over-qualification	Due to a mismatch between the skills of the individual and the skills required by the health service, some respondents thought they were over-qualified for the role in terms of the clinical component of the job. For example on respondent with advanced midwifery skills was employed in a health service that did not have an obstetric service.
Role under-qualification	Most respondents considered that when they first took on the job, their preparation for the management component of the role was inadequate (in some cases non-existent).

The structure of the role, especially in the light of the lack of formal socialisation, created difficulties for the sensemaking process of the DON/HSMs. Because of the inherent ambiguity, conflict and overload, the role became reactive rather than proactive. Many of the respondents reported the need to *go with the flow*; and rather than attempting to resolve the issues of role stress, the DON/HSMs dealt with situations as they arose. In this way

circumstance shaped the role and influenced the sensemaking processes, with the urgent frequently receiving more notice than the important. The events that were noticed more frequently and received the most attention were those that presented themselves and required immediate action.

Sensemaking involves focusing on a limited set of cues and the elaboration of those cues into a plausible, pragmatic guide for actions. This may often involve ignoring much that others might notice (Weick, 2001). The implication is that the individual makes a choice about which cues are salient to their sensemaking and which are not, leading to a "sizing up" of the situation. The influence of these "size ups" is enduring because once a hypothesis is formed, people tend to look for evidence that confirms it. This tendency is particularly strong when people are under pressure to act quickly, and it is hard for them to find the time to question their initial beliefs (Gilbert, 1991). In this way, the reality that the DON/HSM discovered and that stimulated their behaviour in their role was greatly affected by the role stress created by the organisational structure.

7.3.4 Implications of structural elements

The structural elements proposed in the model are interrelated and interdependent in an ongoing iterative cycle of cause and effect. Role stress encourages political behaviour that, in turn, threatens feelings of trust. Similarly political behaviour contributes to role stress, and trust (and perceptions of trustworthiness) contribute to role stress and political behaviour. In this way, each structural element can be viewed as both an antecedent and a consequence of the other. Conceptually, this is best illustrated by intersecting circles as shown in Figure 7.2.

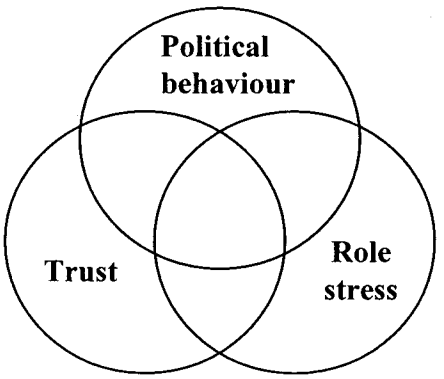

Figure 7.2: Structural elements of the DON/HSMs' role

All the structural elements and the interface between them influenced the sensemaking process of the DON/HSM in their role as clinician manager. These influences will be discussed in more detail in section 7.5.

7.4 The DON/HSM as clinician manager: personal elements of the sensemaking process

Drawing from the proposed model, this section discusses the characteristics of the individual that mediate the sensemaking processes of the DON/HSM in their role as clinician manager; i.e. trust, political behaviour and role stress.

7.4.1 Role strain

The experience of role strain was a recurrent theme in the data. All respondents reported role strain and spoke at length of the consequences of role stain for themselves personally and for their job performance.

Theoretical perspectives

Whereas role stress is created by the structural conditions that determine role obligations, role strain is the subjective state of emotional arousal in response to that role stress. Role strain may be experienced by a role occupant as increased levels of awareness, general emotional arousal, or such feelings as distress, anxiety or frustration (Hardy and Hardy,

1988). By failing to sufficiently socialise the DON/HSMs into their new role, the organisation added to the role stress inherent in the position and thus contributed to role strain. On the other hand, role strain will invariably accompany major efforts at role transition and may be a prerequisite to new learning. Ward (1986, p. 41) defined role strain as an "undesirable state perceived by the individual within a role arising from the stress associated with the role". In this way, role strains are not the stressful antecedents influencing a role but the conditions or manifested outcomes of the influence of those antecedents; i.e. the "felt difficulty".

The responses to role strain have received some attention in the literature. Responses are generally classified as psychological or physiological responses. The physiological responses to stressors is a syndrome described by Selye (1956) as the General Adaptation Syndrome (GAS). Galvanic-skin-response changes, increases in diastolic blood pressure and rises in plasma-free fatty acids have been noted in response to role strain (Williams, Kimball and Willard, 1972). Psychological responses, however, are less easily measured. Much of the literature focused on the stressors and the strategies employed to resolve the situation. Less attention had been given to the affective experience of the individual. Ward (1986), following a review of the literature, identified individual responses to role strain as worrying or thinking about the stressors within the job; feelings of frustration, failure and insecurity; fatigue and exhaustion; embarrassment; tension, anger and hostility; indecision and anxiety. Responses ranged from feeling frustrated to experiencing extreme guilt and anxiety.

Not all authors have considered role strain negative or detrimental (Coverman, 1989) with some suggesting that role strains may be desirable and actually enhance performance (Jones and Deckro, 1993; Stryker and Macke, 1978). While not disputing the undesirable state of role strain for many, it is suggested that role stress may produce, not role stress, but role gratification. Similarly, such responses as fatigue, anxiety and perceived difficulties related to role stressors might invoke divergent manifestations. Individual responses to role strain may show marked variation.

Cote and Yehle (1991), following an examination of the literature that attempted to explain role strain in organisations, observed that despite the large number of empirical studies conducted, the areas of inquiry remains vexed, with widespread dissatisfaction with the progress made. Difficulties lie in the different measures used for the concepts, differing assumptions and different types of organisations. This view is supported by Flynn (1998) who also suggested that the multidisciplinary nature of the research on role compounds the difficulty in identifying relevant literature. Despite the difficulties in developing a framework that adequately described role strain, there was general agreement that role strain was a consequence of difficulties in fulfilling role obligations, and that individuals experienced the strain in different ways.

Discussion

All the respondents in this research reported experiencing manifestations of role strain, describing emotional responses such as anger, frustration, doubt, panic and anxiety. This led to an emotional response to the job itself, with such responses ranging from *I hate this job* to *I love this job*. Many commented on the impact of role stress on their personal lives with the perception that the failure of personal relationships was a direct consequence of the stress that they felt in the job.

Role strain was felt in both the clinical and management components of the role. The emotional elements of the clinical component and the responsibility of dealing with life threatening emergencies involving personal friends and acquaintances was frequently identified as stressful. Role strain in the management component of the role commonly related to role under qualification, with many commenting that *in the beginning I had no idea what I was doing*. The role strain felt in the clinician manager role related to role ambiguity and role conflict between the clinical and management components. The most frequent contributor to role strain, however, was seen as being role overload. Persistent themes were that the job was too big and there were not enough hours in the day to meet the demands of the role.

Whether or not emotion disrupted or energised adaptive functioning was unclear. Some respondents were clearly overwhelmed by their experience of role strain; whereas, others

saw it as an expected consequence of a new and exciting job. With respect to sensemaking, the issue is the impact of the emotional response on behaviour. Weick (2001), following a review of the literature, suggested that the issues were not resolved. It appeared that an increase in emotional intensity from some zero point produces an increase in the quality of the performance up to some point, beyond which performance deteriorates and is finally disorganised.

In the initial stages, where emotional responses are associated with high levels of arousal, attention is likely to be increased. More issues are noticed and sensemaking is heightened. There appeared to be a tendency with the respondents to cling to areas with which they were familiar. Many of the respondents, especially those in groups 1 and 2, related how, in the first instance, they fought to maintain their clinical role. It was not clear whether this was because they liked their clinical role so much or because it was a familiar way of behaving and as such created less stress. Some said that they did as much clinical as they could because *at least I know what I am doing there.* That the management component of their role increased over time is, no doubt, related to the increasing demands of the responsibilities, but it may also be related to the notion that with the passing of time they became more comfortable with that component of the role.

It is proposed that sensemaking and enactment increase the understanding of the role. These processes are moderated by emotional responses to role stress that, in turn, affects perceptions of role strain and increases attention to salient cues. This impacts on job-related behaviour that, in turn, influences sensemaking in an iterative cycle. This is summarised in Figure 7.3.

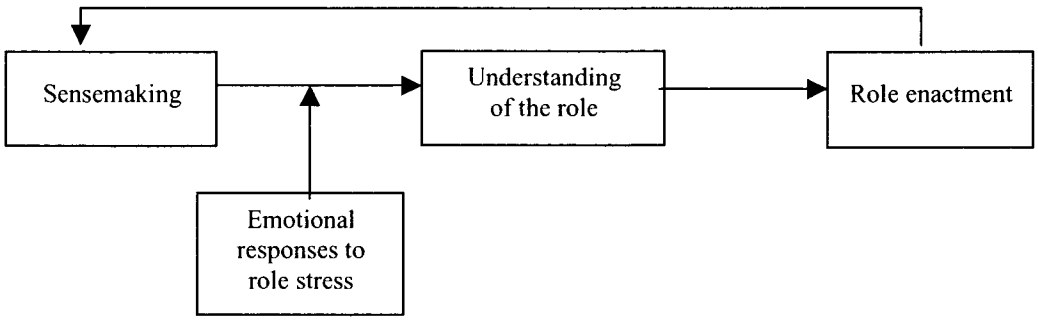

Figure 7.3: Role strain and sensemaking

This model does not, however, explain the observed individual variation in the emotional responses to role stress. It is proposed that self-efficacy and commitment, the next components of the theoretical model, influence this.

7.4.2 Self-efficacy

The data suggested that there was considerable variation if the respondents' assessments of their self-efficacy. While many reported high levels of self-efficacy regarding their clinical abilities, many expressed low self-efficacy about the management component of the role. Despite this, assessments of self-efficacy in terms of the clinician manager role was variable.

Theoretical perspectives

Self-efficacy refers to people's judgements of their capability to accomplish a certain level of performance (Van Vianen, 1999). Gist and Mitchell (1992), following a review of the literature, suggested that self-efficacy has been consistently shown to influence the goal level and the goal commitment, job performance, the individual's choice of activities, tasks and coping efforts while engaged in these tasks, the interpretation of feedback and affective reactions to the task. These findings support Bandura (1997, p.3) who suggested that self-efficacy beliefs have diverse effects, influencing the courses of action people choose to pursue, how much effort they will put into such actions, how long they will persevere in the face of obstacles and failures, their resilience to adversity as well, and how much stress and depression they experience in coping with taxing environmental demands. Thus, given the

same level of skill, a person will perform poorly, adequately or extraordinarily, depending on self-efficacy (Bandura and Wood, 1989).

Bandura (1997, p.79) proposed that self-efficacy beliefs are constructed from four principal sources of information:

- enactive mastery experiences that serve as indicators of capability;
- vicarious experiences that alter efficacy beliefs through transmission of competencies and comparison with others;
- verbal persuasion and allied types of social influence that one possesses certain capabilities; and
- psychological and affective states from which people partly judge their capabilities, strength and vulnerability to dysfunction.

Any given influence, depending on its form, may operate through one or more of these sources of efficacy information. Bandura pointed out, however, that information relevant for judging personal capabilities only becomes instructive through cognitive processing and reflective thought. Cognitive processing is affected by the types of information people attend to and use as indicators of personal efficacy and the way in which individuals weight and integrate efficiency information from different sources in constructing their beliefs.

In the clinician manager role, there is a need for the creative and persistent use of a complex set of capabilities in order to exercise some control over the environment and the organisation. Success in forming and enacting these complex capabilities is mediated by self-efficacy. Operative self-efficacy is a generative capability in which multiple skills must be continuously improvised to manage ever changing circumstances (Bandura and Wood, 1989, p. 805). Those with doubts about their efficacy are likely to view the environment as uncontrollable and therefore limit their behaviour. On the other had, those with firm beliefs in their efficacy, assume that their environment can be enacted and that they have the capability to do so. Acting on this assumption, those with high levels of self-efficacy are motivated to make strong persistent job-related efforts, increasing their likelihood of

success. In this way, self-efficacy has similarities to a self-fulfilling prophecy (Weick, 2001). Those with low levels of self-efficacy limit their behaviour and perseverance thus decreasing their chances of success and confirming their perceived low self-efficacy.

Individuals assess their self-efficacy in a particular circumstance by invoking personal schemas, developed from previous experience, vicarious experience or experience with other tasks. Self-schemas of efficacy are formed and adapted through experience (Wood and Bandura, 1989) which implies varying degrees of cognitive activity. Gist and Mitchell (1992), drawing on previous literature, suggested that judgements about efficacy become more routine and automatic as experience with the task increases. When tasks are novel or considered to be important, a more detailed analysis is likely. In more normal circumstances, or "business as usual", the individual is more likely to refer to previously developed personal schemas as a primary determinant of self-efficacy. Louis and Sutton (1991) made the distinction between "habits of the mind" and "active thinking" and suggested that errors occur because people fail to recognise the presence of conditions when they should switch from automatic processing to active thinking.

Discussion

The data from this research indicated that self-efficacy was an important factor in the respondents' adaptations to their new roles. Most of the respondents started their new role with high levels of self-efficacy in the clinical component of the role. Those in groups 1 and 2 had extensive experience, not only in clinical practice, but also in clinical practice in the specific health service; and they were confident of their abilities. Those in group 3 had more variable assessments of their clinical abilities. Some, who had been in managerial positions immediately previous to assuming the DON/HSM role were less confident of their clinical skills. Similarly, others who had come from clinical speciality positions in metropolitan hospitals found that they were not as well prepared as they had expected. The general nature of clinical practice in the rural health services required a much broader clinical base, and their experience in such areas as aged care and mental health nursing was more limited. Nevertheless, it was apparent that the clinical component of the role was considered to be more familiar, and that personal schemas based in previous experience fitted more readily.

The data suggested, however, that for some respondents their feelings of self-efficacy related to clinical practice decreased rather than increased with their experience in the role. As the management element of the role became more demanding, "hands on" clinical practice became less a part of the role. Although most maintained a role as a clinical resource person and filled an emergency relief role, their clinical skills lessened, especially in the area of new technology.

Levels of self-efficacy with respect to the management component of the job were much lower. Many readily admitted that they knew nothing of the tasks the role entailed. This did not seem to affect, however, their confidence in their ability to perform the job. The data suggested that most assumed that, given time, they would meet the demands of the role. When asked the source of this confidence, none were able to offer a causative explanation. The general feeling was that *we are nurses, and we will cope.* Some admitted that their confidence in the first instance might have been somewhat naive, reflecting a lack of understanding of many dimensions of the role. They hastened to point out, however, that everybody else, including the architects of the role, also lacked understanding.

Similarly, the assessment of their ability to cope with the conflicting demands of the clinical and management role did not appear to be an issue in the first instance. There was more concern about coping with the increased work load than with the problems of integrating the two dimensions of the role into a coherent whole. Concerns about integration emerged with experience in the role and estimations of self-efficacy were threatened as the increased complexity of the role and as the numerous role demands became apparent. Self-efficacy appeared to be curvilinear, commencing at a relatively high level, and decreasing as the individual was faced with the realities of the role and increasing again as experience in the role led to a perception of role mastery. Assessments of self-efficacy relating to both the clinical and management components of the role are depicted in Figure 7.4. The slopes of the lines are estimations and intended for illustrative purposes only.

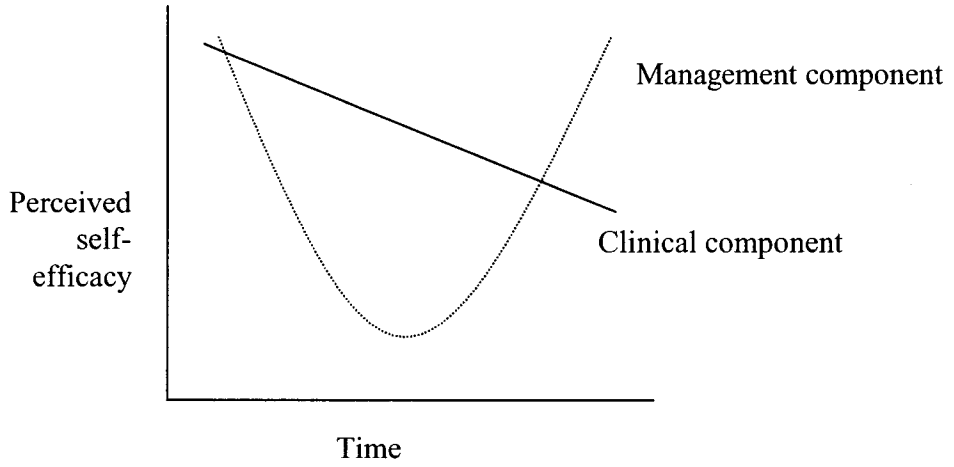

Figure 7.4: Perceptions of self efficacy in management and clinical roles

Where the two lines intersect on the upward slope of the management curve suggests a point where the DON/HSM had roughly equal estimations of self-efficacy in both components of the role, and believed that they could successfully perform in either area. Some believed that they were at that point. These respondents were in smaller health services where they were able to maintain more "hands on" clinical practice than those in larger health services. The graph, however, also suggests that as self-efficacy increased in the management component of the job, clinical self-efficacy decreased. This was an observation made by a number of respondents. What was not clear was where the ideal position would be for the optimal performance in the role.

Efficacy judgements, as with sensemaking, require the analysis of a large number of cues, and more cognitive effort is expended in attending to tasks and situations that are novel and for which there is no ready fit with personal schemas. For this reason, sensemaking in the clinician manager role is probably directed more towards management situations than the more familiar clinical roles. It is not until the DON/HSMs are comfortable with both components of the role that the roles can be integrated and sensemaking can be influenced

by cues that are salient to the role rather than those that are attended to because of the novelty of the task.

High levels of self-efficacy are not necessarily the logical outcome of the enactment of the DON/HSM role. The data suggested that there was wide variation in the respondents' perceptions of their self-efficacy in the clinician manager role as a whole, ranging from some who expressed considerable self-doubt to a few who were extremely confident.

There were sources, both internal and external, that mediated perceptions of self-efficacy. The influences that emerged from the data are summarised in Table 7.6 in relation to the four principal sources of self-efficacy proposed by (Bandura, 1997). (See the previous discussion.) It is proposed that influences from these sources can have both a positive and negative effect on self-efficacy.

Table 7.6: Sources of self-efficacy

Source of self-efficacy	**Positive Influences**	**Negative influences**
Enactive mastery	Perceptions of: • correct establishment of priorities • successful completion of required tasks	Introduction of: • new management procedures • new clinical technology
Vicarious experiences	Networking with other DON/HSMs and open and honest sharing of experiences	Perceptions: • of the isolation of the role • that their situation is unique and not comparable to any other
Verbal persuasion	Positive feedback from a trusted source	Feedback (positive and negative) from a source which is not trusted
Affective states	• A feeling of coping with and control over role stress • Invigorated by role strain	• A feeling of not coping with or having any control over role stress • A feeling of being overwhelmed and not coping with role strain

The impact of self-efficacy on sensemaking was diverse, affecting many elements of the sensemaking process. Personal identity was affected with the move from a clinical position where the individual experienced high levels of self-efficacy to a position where estimations of self-efficacy were low. This threatened respondents' self esteem.

The concept of self-esteem, although related to self-efficacy is a distinct construct. Perceived self-efficacy is concerned with judgements of personal capability; whereas, self-esteem is concerned about judgements of self-worth (Bandura, 1997). Self-esteem is generally considered to be a trait and therefore global in orientation, it may be also considered to be related specifically to the organisational context (Gardner and Pierce, 1998). Beliefs that individuals have about themselves in that context have strong implications for their work-related motivation, attitudes and behaviours (Pierce, Gardner, Cummings and Dunham, 1989). The data from this research suggested that for a number of respondents, perceived low self-efficacy, especially related to the management component of the DON/HSM role threatened self-esteem. This affected sensemaking as it influenced the choice of salient cues and the amount of effort and perseverance that the individual put into the actions and interpretations needed to keep pace with the changing and ambiguous environment. Explanations of events, in the case of some respondents, appeared to be biased by their lack of confidence in their own actions.

7.4.3 Commitment to sensemaking

A commitment to the sensemaking process was an important element in the adaptation to the new role of the clinician manager. Although much of the sensemaking process can be considered to be an automatic cognitive activity, sensemaking in new roles, especially those characterised by complexity and ambiguity, requires considerable cognitive effort. Personal schemas need to be modified in the light of new circumstances and new schemas developed as understanding and explanations of new experiences grow.

The success of the sensemaking process is related to the amount of cognitive effort the individual makes. It is proposed that the amount of cognitive effort is related to the

commitment the individual has to the sensemaking process. In this context, commitment is defined as the willingness to exert considerable effort in sensemaking. The data suggested that the commitment of the respondents to sensemaking could be explained by expectancy theory.

Expectancy theory, proposed by Vroom (1964), assumes that people are rational decision makers who will expend effort on work that leads to desired rewards. There are four central components of the theory:

Job outcomes:	This includes rewards such as promotion and negative experiences such as job loss.
Valences:	The individual's feelings about the job outcomes range from positive to neutral to negative and vary in strength.
Instrumentality:	This is the perceived link between performance and outcomes; i.e the extent to which individuals believe that attaining a job outcome depends on, or is conditional upon, performance
Expectancy:	This is the perceived link between effort and performance

Motivation is the end product of valence, instrumentality and expectancy. Expectancy theory rests on the assumption that people are highly rational and consciously engage in decision to work harder on tasks that they believe will maximise their gains while minimising their losses. Empirical and theoretical support from many studies of expectancy theory is mixed (Van Eerde and Thierry, 1996), with the more support being received in studies that examine the level of effort an individual will expend on different tasks than in studies that examine the strength of motivation across different people.

The data from this research suggested that the respondents did indeed make rational choices about the degree of effort they would expend in the sensemaking process and that this effort was directly related to their assessment of the valence of the outcomes. The commitment to sensemaking, however, was variable and showed important differences across groups. While most expressed a commitment to the concept of a clinician manager role, there was some disagreement about whether the role was "doable" or not. A

commitment to sensemaking, however, appeared to be more related to the individuals' assessment of their personal investment in the role. Those in groups 1 and 2, locals who perceived their job options to be minimal, were highly motivated to create a role in which they could perform well. Sensemaking was seen as inherent in moulding a role that was manageable from their own point of view but was also acceptable to the other stakeholders. Seeing themselves as incumbents of a role that was considered successful and therefore ongoing, was the outcome that they saw as a reward for their efforts. Cognitive effort exerted was seen as instrumental to this outcome.

The respondents in group 3 were less clear in their commitment. Many took the position of DON/HSM for a multitude of reasons but mainly to seek career advancement or a change of lifestyle. Most did not have previous rural experience. On taking the job, some found that the rural experience was not to their liking. More importantly, they found the role that they had undertaken was extremely difficult and required complex skills and perseverance, often in the face of adversity. They also found that by taking the job they had compromised their future career opportunities. Rather than career advancement, the job limited their alternatives, and a return to a position in the metropolitan area was problematic. In addition, the future of the role itself was far from certain and possibly could be changed in further restructuring of rural health service. In the light of these discoveries many could and did make rational decisions about their commitment to the sensemaking process. The data suggested that some decided that their stay in the role would be short lived. Sensemaking for these respondents was minimal as they interpreted the new situation in terms of personal schemas developed from previous experience elsewhere. This degree of sensemaking was sufficient to achieve their desired outcomes, employment while seeking alternatives. Not all in group 3 subscribed to this minimalist approach. Others can and did expend considerable effort in sensemaking as they aimed for the best job performance they could achieve.

It was also apparent that sensemaking for those in group 3 was more challenging than for those in the other groups. Not only did they have to cope with a new role but also a new organisational environment and social environment. Resorting to familiar personal schemas

may have been as much a survival technique as a rational decision to do so. Nevertheless, the data supported the notion that some in group 3 did not express the high levels of commitment to sensemaking as did those in groups 2 and 3.

7.4.4 Implications of personal elements

It is proposed that personal elements influence the sensemaking processes of the DON/HSM in the clinician manager role. The personal elements considered salient to the model, however, are not interrelated and interdependent in the same way that it is proposed that the structural elements are. Each of the personal elements may function independently and are influenced by factors other than the job itself. For example, experiences of role strain may influence self-efficacy negatively or positively and have little effect on the commitment to sensemaking.

It is proposed, however, that these elements are characteristics of the individual and, as such, have a significant impact on the sensemaking processes. Conceptually, this is illustrated by circles that are touching but do not overlap. These are, in turn, enclosed in a larger circle indicating that these are characteristics of the individual person. See Figure 7.5

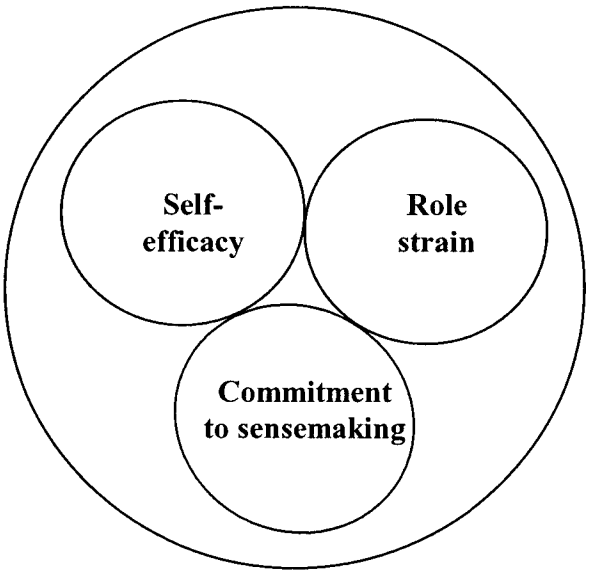

Figure 7.5: Personal elements of the DON/HSM's role

All personal elements influenced the sensemaking process of the DON/HSMs in their role as clinician manager. These influences will be discussed in more detail in section 7.5.

7.5 Sensemaking

The sensemaking process of the DON/HSMs suggested by the data will be explained in terms of the seven properties of sensemaking described by Weick (2001). These properties have been chosen to organise the discussion because they represent a synthesis of the literature and appear to represent a comprehensive summary of the key aspects of sensemaking.

7.5.1 Social context

Sensemaking is influenced by the actual, implied or imagined presence of others; and sensible meanings are most accessible for those for whom there is social support (Weick, 2001). The social nature of sensemaking reflects its theoretical underpinnings in symbolic interactionism because Mead (1934) was adamant that mind and self arise and develop within the social process. Thus sensemaking focuses on the social interaction and the pursuit of meaning in that context. The outcome of social interaction, however, is not necessarily a shared meaning but more the formation of a working relationship achieved by the fitting together of acts to form a joint action (Blumer, 1969, p. 76). Blumer suggested that participants may fit their acts together in "orderly joint actions on the basis of compromise, out of duress, because they may use one another in achieving their respective ends, because it is the sensible thing to do, or out of sheer necessity".

The data suggested that although the social interaction of the DON/HSMs tried to achieve a workable compromise with the stakeholders with respect to the enactment of the role, many did not believe they had achieved this. The establishment of working relations was one of the most problematic facets of the role. That the stakeholders had differing and often conflicting expectations and needs of the role (see Table 7.2) made the establishment of acceptable compromises with all stakeholders at one given time difficult and, in the view of some, impossible. This served to encourage and enhance the political behaviour of all parties. The lack of trust that many of the DON/HSMs felt further compromised any social

interaction, leading to doubt in the motives of others when there appeared to be a convergence of values and reservation about the future of any seeming agreement. Nevertheless, as pointed out by Blumer (1969, p. 8) "the actions of others have to be taken into account and cannot be regarded as merely an arena for the expression of what one is disposed to do or sets out to do". Despite the often conflicting and doubtful interaction with the various stakeholders, the DON/HSMs could not ignore them, and the activities of these others was a positive factor in the formation of their own conduct.

Many of the respondents resorted to internal conversations in order to decide how the demands of others would impact on their role. As pointed out by Weick (1995), sensemaking is never solitary because what a person does internally is contingent on others. Even conversations with oneself assume an audience. This is consistent with the symbolic interactionist view point proposed by Mead (1934). Many respondents revealed distress that they were unable to test the conclusions drawn and behaviour planned in these internal monologues. Although some used relationships with other DON/HSMs as a test arena and some referred to others with whom they had established a relationship of trust, many observed that each DON/HSM position was unique, with different dynamics between the stakeholders. What was appropriate compromise behaviour in one health service may be destructive in another.

The degree of comfort the DON/HSMs felt with these internal conversations was clearly related to their degree of self-efficacy. Those with high levels of self-efficacy found conversations with oneself to be a reasonable and productive way of planning behaviour when attempting to develop a working relationship with the different stakeholders. The isolation of the role, with responsibility and accountability in an environment of conflicting demands, did not appear to particularly worry such respondents. Some even found this to be one of the best features of the role. Those with low levels of self-efficacy found the need to rely on conversations with oneself further eroded the confidence they felt in their ability to carry out the role. These respondents felt the lack of support for the role most acutely.

7.5.2 Personal identity

Weick (1995) suggested that the establishment and maintenance of identity is a core occupation of sensemaking, and to shift among interactions is to shift among definitions of self. From this point of view, the sensemaker is undergoing continual definition, coincident with presenting some self to others and trying to decide which self is appropriate. The issue of personal identity is one of the major issues for those adopting a clinician manager role. The question of whether those in the role are clinicians, managers or have some new — yet to be clearly articulated — identity representing a combination of both continues to be debated in the literature (Thorne, 1997; Willcocks, 1994; Willmot, 1998). The data suggested that this research did not resolve this issue of identity.

That the DON/HSMs had different identities for each of the stakeholders was a recurrent theme in the data. Most reported that the patients and the community still saw the DON/HSM as the "Matron", a traditional nursing role characterised by strict authority, imposing presence and a white uniform with a veil (Flynn, 1998) and frequently expressed disappointment when the DON/HSM did not act accordingly. Some respondents complained that the health service board has a similar vision of the DON/HSM role. The health service staff also had an unclear image of the identity of the DON/HSM with nursing staff referring to the incumbent as the DON and the support staff referring the them as the HSM or, in the case of older staff, the Matron. Most felt that the general practitioner saw the DON/HSM as a nurse and considered their management responsibilities to be an unfortunate addition to the role. The DON/HSMs' perceptions of the general managers view of their identity changed according to political expediency. The HDWA was thought to have high expectations of the management component of the role, but when it came to issues of industrial relations still treated the DON/HSMs as *silly little nurses*. If, as Weick (1995) proposed, people learn about their identity by projecting it into the environment and observing the consequences, the messages the DON/HSMs are receiving cannot be considered helpful. The identities that the DON/HSMs in their role of clinician managers projected can and did change frequently.

When asked how they saw themselves, most respondents reacted with some confusion. The general consensus was that *I am a nurse, but what I do is management.* It was apparent that with respect to their role as a clinician manager they did not have a clear sense of identity. This confusion regarding their professional self-identity was further enhanced by the perceived lack of alternative employment opportunities that would acknowledge their acquired skills and the generally held view that the role itself was an experiment and, as such, may not be ongoing. Developing an identity in the context of a role that has an uncertain future was seen by some as detrimental to their professional future.

The implications of the confused sense of professional identity in the clinician manager role had implications for the sensemaking of the DON/HSMs. Sensemaking is triggered by a failure to conform to one's self and serves to maintain a positive self-identity. Cues for identity are taken from the conduct of others, but individuals make an active effort to influence this conduct to begin with. If the identity of the clinician manager role and the identity of those in that role is to serve as a general orientation to situations that maintain esteem and consistency, DON/HSMs themselves needed to begin in the role with a sense of identity that they seek to maintain. The data suggested that, despite some exceptions, this generally did not happen. Even the title of the role sent a confused message. The title of DON/HSM has been used in this research for the sake of consistency but respondents called themselves variously HSM/DON, DON or HSM. Some preferred the title DON/HSM because it placed nursing first. Others preferred the title HSM because they believed it to be more professionally prestigious. Uncertainty regarding identity was apparent.

Most took on the role without a clear identity in the role and shaped their identity in the light of cues from others. Support was found for Leonard, Beauvais and Scholl (1999) who suggested that a lack of feedback — or ambiguous or inconsistent feedback — results in weakly held self-perceptions. That respondents, some whom had been in the position for a number of years, were unable to clearly articulate a self-identity in the role can be attributed to the general confusion of the stakeholders regarding the nature of the role.

Sensemaking where one does not have a consistent self-conception can only be considered problematic for the individual and for the development of the role.

7.5.3 Retrospect

One of the distinguishing characteristics of Weick's (1995) conceptualisation of sensemaking is the focus on retrospect. Weick takes the view that the creation of meaning is an attentional process, but it is attention to that which has already occurred. People's sensemaking of what is happening at any one point in time will be influenced by what has happened in the past. Meanings are ascribed to current events following reflection on previous events. Similarly, explanations of previous events are influenced by the present, with memories and interpretation of past events unconsciously adjusted to current events. Retrospective sensemaking is an activity in which many possible meanings may need to be synthesised, with the problem often being too many meanings. People are overwhelmed by choices between actions that seem equally appropriate in the situation. The nature and meaning attributed to past events will impact on current decision making. Weick argued that people need values, priorities and clarity about preference to help them be clear about which projects matter.

The notion of retrospective sensemaking had a number of implications in this research. First, the basic assumption seems to be that there is a previous experience that is relevant to the present. Weick (2001, p. 462) suggested that when people refuse to appreciate the past, their acts of retrospect are "shallow, misleading, and half-hearted and their grasp an reality begins to loosen". The degree to which past experience can be considered relevant to a new position such as that of the clinician manager is open to question. That there was no precedence for the position has been an ongoing theme in this research. The incumbents had to draw on previous experiences that could be, at best, approximated to the current situation. Most acknowledged this process of approximation when planning action and conceded its limitations. In this way the diverse individual experiences of the respondents contributed to the different ways in which the role had developed.

Experience in the role provided memories more relevant to the role. Explanations of previous situations provided guidance for sensemaking in new situations. The length of time the individual had been in the role clearly impacted on the usefulness of such retrospectivity. When reflecting on past events that had influenced their decision making, and hence shaped the role, the themes that emerged from the data were remarkably consistent. Most reported memories of events and actions influenced by the interface between — and the demands of — the stakeholders and the effects of the ambiguity of the role, the questionable trustworthiness of individuals and the political behaviour in which they became involved.

7.5.4 Salient cues

Sensemaking is based on noticing cues considered to be salient to answering the question "What is going on here?" The sensemaking process responds to cues from the environment. Cues are the hints, events or other phenomena in the environment from which people develop a larger sense of what may be occurring. Cues serve as points of reference that direct attention for sensemaking, which is the act of interpretation and determining what the noticed cues mean. Noticing describes the more informal and involuntary beginning step in sensemaking. When events are noticed, people make sense of them, but if events are not noticed, they are not available for sensemaking.

The data suggested that the noticing of cues is of issue in this research. Elements of role strain, particularly role overload and role ambiguity, impact on the cues that are noticed. Role overload and the notion that the DON/HSM role is very busy affects the cues that can be noticed. In the passage of a busy day, cues remain unnoticed. Similarly, role ambiguity makes it difficult to judge which cues are salient. Lack of experience in the role contributes to the judgement of salience as does lack of experience in previous roles. Personal schemas are of limited value when judging salience when the relevance of such schemas is doubtful.

Noticed cues also lead to interpretation of the behaviour of others as being political in nature or untrustworthy in a self-referential way. Cues may be used as confirming evidence and, in this way, may be filtered or used selectively. Lack of trust caused individuals to

reject cues because they were not thought to be trustworthy. Such cues were noticed and incorporated into the sensemaking process, but were used selectively. Political behaviour drew attention to particular cues that reflected the vested interests of the various stakeholders. In this way the stakeholders influenced the sensemaking processes of the DON/HSMs by focusing attention on a particular aspect of the role. While attending to one aspect, other cues remained unnoticed.

Personal characteristics of the DON/HSM also impacted on the cues that were noticed. High levels of self-efficacy and a resultant confidence in the job increased the number and subtlety of the cues that were noticed. Similarly role strain and the commitment to the sensemaking process also affected the cues noticed.

The position of the DON/HSM has changed considerably since its inception, with the responsibilities of the role and the expectations of the stakeholders changing. Time has served to emphasise the elements of the sensemaking model developed for this research rather than diminish them. Cues, for this reason, have become more contradictory and unstable, making it increasingly difficult for the DON/HSM to retain a firm grasp on what is happening. Those who have been in the position the longest and survived (mainly those in group 1) have now developed a body of experience on which to draw. This makes them more able to cope with the dynamic role. Those in groups 2 and 3 are in a less enviable situation, and many of them are still trying to find cues that will indicate to them what is happening.

7.5.5 Ongoing projects

Experience is a continuous flow, and in order to understand the clinician manager role, the DON/HSMs in this research had to place boundaries around some portion of the flow. Limits to human cognitive abilities made attention to all aspects of the experiences in the role not possible. In this way, the sensemaking process was constrained, not only by past events, but also the speed with which events flow into the past and with which interpretations become outdated. The DON/HSMs were forced to act without a stable sense of what was happening. This was not necessarily related to personal shortcomings but was

more related to the pace of ongoing events. The pace of ongoing events created a need to continuously update actions and interpretations.

The need for this constant updating contributed to and was affected by role strain. The continual cognitive effort required to deal with a continuous flow of novel situations contributed to the stress felt by the respondents. Those who felt overwhelmed, frustrated and angered by these continual demands were less likely to be able to cope. Equally, those with low levels of self-efficacy had their self-confidence further eroded by changing experiences.

The data suggested that a number of respondents found difficulty when a situation with which they had struggled to cope suddenly changed and their efforts were no longer relevant. They then needed to find the energy to cope with another ambiguous and demanding situation. The constantly changing circumstances denied them the degree of stability they were seeking. It was in such circumstances that some took the view that ongoing sensemaking was *too hard*, and their commitment to the sensemaking process became less. In the face of repeated experiences of this nature, commitment to sensemaking continued to be eroded. On the other hand, others viewed the ongoing nature of experience to be a challenge. While a few claimed to be invigorated by it, there was a general feeling that this was an inherent part of the role and coping was essential to doing the job.

7.5.6 Plausibility

Sensemaking relates to developing plausible explanations about what has happened. It is these plausible explanations that are reached when situations are matched to personal schemas. The elements of the situation are imposed on the elements of the schema, which in turn, outlines expectations within certain ranges of acceptability. It information is missing, default values are inserted that allow the perceiver to go beyond the information given. This raises the question of the accuracy of schemas, and this issue has received some attention in the literature (Bartunek and Moch, 1987; Harris, 1994; Wagner and Gooding, 1997). It does appear, however, that the accuracy of schemas has little meaning for sensemaking. Schemas, by their nature are reconstructions of the past and rely on memory.

As events never occurred precisely the way they are remembered (Fiske, 1993), accuracy itself becomes a perception. That the individual believes their recollections — and therefore considers the explanation to be plausible and a basis for actions — is the issue that is fundamental to sensemaking. Plausible explanations, although formed by personal schemas, are tested not so much by personal recollections but by consistency and the agreement of others.

The ability of the DON/HSMs to develop plausible explanations is compromised by two factors. Lack of experience in the position and lack of experience with the management component of the role meant that many did not have developed personal schemas on which to draw. Lack of relevant experience meant that their ability to "fill in" gaps in their schemas was limited. Any plausible explanations made were tested against the explanations of events made by others. Lack of trust in other stakeholders made any congruence in plausible explanations suspect. Political behaviour made congruence in plausible explanations unlikely.

When there was doubt about the veracity of interactions with others — and in the absence of personal schemas grounded in personal experience — the data suggested that sensemaking becomes a much more isolated process. Most respondents made plausible explanations based on hope, hunches, intuition and "gut feeling. Although such responses may seem groundless, they were held as more plausible explanations about "what is going on" than those formed from interactions with others. Turning to the symbolic interactionist perspective (Mead, 1936), there was much more of a reliance on the "I", the set of attitudes and values assumed by the individual, rather than the "me": those determined by the social environment.

7.5.7 Enactment

Enactment captures the notion that the individual DON/HSM deliberately created the environment rather than solely responding to it. Individuals select, emphasise, modify and/or allocate attention to particular expectations to which they prefer to be held (Weick, 1979). This is particularly the case when role expectations are weak or when the focal

person is forceful (Fondas and Stewart, 1994). In this way people are very much a part of their own environments. They act and, in doing so, create the materials that become the constraints and opportunities they face (Weick, 1995). People create their environments as those environments create them. Thus enactment is an integral part of all aspects of sensemaking and can be understood a much as an input, a process and an outcome of sensemaking.

Enactment does not necessarily lead to an action. Blumer (1969, p. 16), when discussing action in the context of symbolic interactionism, suggested that action consisted of taking account of things noticed and behaving in a way consistent with the interpretation of those cues. The things taken into account cover such matters as wishes, wants, objectives, the available means for their achievement, actions and the anticipated actions of other, self-identity and the likely result of a given line of action. In this process, given lines of action may be started or stopped, abandoned or postponed, confined to planning or changed. Action and inaction can be both have meaning for sensemaking.

The data suggested that across the range of respondents there were different perceptions of the enactment of the role. Some clearly saw that their actions shaped the role in an iterative way. These respondents took firm steps to shape the role in ways that they preferred. Others saw the role in much more reactive terms — as being at the hub responding to the demands of the stakeholders. Although these respondents shaped the clinician manager role by both their action and inaction, they did not appear to perceive their role in these terms. The notion that individuals construct a reality through authoritative acts and that this is related to a forceful nature has been identified by a number of writers (Biddle, 1986; Fondas and Stewart, 1994; Weick, 1995). The data suggested that the enactment of the DON/HSM role was related to the individual's feelings of self-efficacy. This, however, did not appear to be the only explanation.

A number of respondents who had high levels of confidence in their ability to do the job complained that circumstances conspired to prevent them from doing so in a way they would have preferred. A recurrent theme in the data was the enactment of the DON/HSM

was constrained by unforeseen circumstances. The supply of appropriately qualified staff, the support of the health service board, collaboration with the general practitioner and the cooperation of the General Manager all conspired to create a situation over which the DON/HSM had varying degrees of control. How these stakeholders interfaced with each other and with the DON/HSM influenced how the respondents perceived their ability to shape the role, regardless of their "forceful" nature or their levels of self-efficacy.

Nevertheless the notion of a "forceful" nature was a persistent idea in the data. Many respondents spoke of other DON/HSMs (and whom they considered to be successful in the role) in terms of their strength and their ability to impose their ideas on others. Most attributed these abilities to characteristics of personality.

The data suggested that many of the respondents recognised that their actions were public and hard to undo. In taking action, they were committed to these actions. Weick (1993b, p. 19) suggested that explanations are developed retrospectively to justify committed actions and these are often stronger than beliefs developed under less involving conditions, as "more of the self is on line". From this point of view, the research found support for Wagner (1997) who, following an investigation of managerial sensemaking, found that there was a tendency for individuals to attribute instances of personal success to internal, personal causes and attribute instances of personal failure to external, situational or environmental causes.

A recurrent theme in the data was that the achievements in the DON/HSM role could be attributed to the insight and endeavours of the incumbent. Failures were attributed to external factors such as the trustworthiness of stakeholders, political behaviour, the physical environment and the availability of suitable staff. Whether or not such attributions were accurate or not is not the important issue. The respondents believed in and were committed to these explanations. They acted and planned future actions based on these beliefs and incorporated these beliefs into their sensemaking processes.

The properties of sensemaking that have been discussed, although presented in a sequential way, are interrelated and interdependent. The properties of sensemaking are also iterative and ongoing. As suggested by the proposed model, the data indicated that the sensemaking processes of the respondents impacted on their understanding and adaptation to their new role.

Chapter 8: Conclusion

8.1 Introduction

This research sought to describe the sensemaking processes of clinician managers in rural Western Australia in their adaptation to their new role. The overall aim of the research was to explore the DON/HSMs' perceptions of their experiences in their adaptation to and their enactment of the clinician manager role. From the perspective of the DON/HSM, the research objectives were to:

1. Identify expectations of the role in the context of previous experience.
2. Describe surprises encountered in the role.
3. Identify cues for sensemaking extracted from and acted upon in the environment and the process of change in personal schemas.
4. Investigate the social processes involved in attributing meaning to the role.
5. Explore the sense of identity related to the development of the new role.
6. Describe incumbent's interpretations of the role (adaptation) and the behaviours considered appropriate for the role (enactment).
7. Propose a model linking the clinician manager to the sensemaking process.

Conclusions with respect to each of these objectives are made.

8.2 Concluding discussion

The model that has been developed to explain the findings (see Figure 7.1) will be used to frame the narrative.

8.2.1 Expectations of the role

When undertaking the clinician manager role, the DON/HSMs did not have a reasoned set of expectations regarding the demands of the role or how their previous experience had prepared them for the role.

This is supported by the following observations. When individuals assumed the role their expectations of the role were far from clear. Those in group 1 took on the extra responsibilities of the administrator's role without an expectation of an increase in remuneration or a change in job classification. They are still paid as Level 5 nurses and at award rates under the *Nurses Public Hospital Award (1998)*. While all in this group considered that they had little choice but to accept the role, many acknowledged that their main expectations lay in an increased authority and more control over the delivery of health services. It was considered that the removal of the administrator would eliminate the long-standing conflict over the management of the health service budget. Although most admitted that they had little knowledge of issues such as financial management and industrial relations, there appeared to have been a high level of confidence that they would be able to do the job. Those in groups 2 and 3, in the first instance, saw the job as a promotion or at least a new career direction. Their expectations about the job lay mainly in terms of personal advantage.

It was apparent that most of the respondents did not have a clear idea of what would be expected of them in the job. The general expectation seemed to be that the role would be the Director of Nursing role with the addition of some management tasks. Most assumed that because the job was a nursing position and they were nurses with experience they would be able to meet the demands of the job. There was the generally held belief that nurses had a long history of coping with difficult situations and that they would cope with this one too.

Many hastened to point out, however, that nobody else had clear expectations of the role either. All stakeholders assumed that the health service would be an ongoing concern but how the new clinician manager role would achieve was unclear and would only become apparent with the passage of time

8.2.2 Surprises encountered

The clinician manager role presented many surprises. These surprises related to the nature of the role, the nature of the practice environment, the political nature of the environment, trust, personal and professional relations, the need to change to a strategic focus, the multiple tasks in the role and the role conflict. The role was found to be larger, busier, more complex and more demanding of the individuals' personal and professional resources than was anticipated.

To support this concluding statement, various surprises are briefly described.

The nature of the role

It became apparent that the role was a management role with some clinical work rather than the other way around as had been expected by most respondents. The rapid growth and increasing demands of the management component of the job and the sophisticated management skills required surprised many. Many found that the management of general staff and health professional other that nurses presented unexpected challenges, and the human resource management elements of the role often became more demanding than learning the new tasks related to the reporting requirements.

The nature of the practice environment

There was the generally held expectation that the practice environment would be rational. Rationality suggests behaviour that can be broadly described as calculated, sensible, logical or instrumental (Dean and Sharfman, 1993) and assumes a logical relationship between past events, current actions and anticipated future effects. Assumptions of rationality underpin clinical practice with the clear relationship between cause and effect being the basis of clinical decision making. That an expectation of rationality, so much a feature of their clinical practice, did not hold for the management environment and, hence, the clinician manager role was a surprise for many.

Rather than a rational environment, the data from this research suggested that the respondents found themselves having to cope with a practice environment that had

parallels in the "garbage can model" of decision making. The garbage can model Cohen, March and Olsen, 1972) proposed that the main components of decisions are problems, solutions, participants and choice situations. These components pour into the organisational garbage can in a continual stream and in a seemingly haphazard way. Every now and then clusters of these components coincide and a decision is produced. Decision processes are seen as unsystematic and lacking in order, with no consistent control that frames decision processes. To illustrate, Cohen et al. (1972, p. 2) described the organisation as a "collection of choices looking for problems, issues and feelings looking for decision situations in which they might be aired, solutions looking for issues to which there might be an answer and decision makers looking for work".

The "garbage cans" in the model are choice opportunities that collect decision makers, problems and solutions. Problems are the concerns of people with access to the decision and are signalled by failures or impending failures. Solutions are answers to problems that may or may not have been recognised. Decision makers move from one choice opportunity to another, and their participation in a particular decision arena depends on features of the alternative choice opportunities. In this view, problems, solutions, decision makers and choice opportunities are linked by the times of their arrival on the scene and the possibilities available at those times. The garbage can model captures the ambiguous and uncertain nature of the operating environment, which much to the surprise of many, became the environment for "business as usual".

The political nature of the environment

The political nature of the role (i.e. dealing with the conflicting demands of the various stakeholders without any clear guidelines for decision making) was a surprise for most. The surprise was not only that others were involved in political behaviour but that the DON/HSMs themselves had to rapidly acquire skills in this area and become involved. There was the generally held belief that the more politically astute the DON/HSM the more likely they were to survive and prosper in the role.

The ambiguity of the role with its muddied lines of authority, which contributed to the political environment, was also a surprise. Most respondents were more surprised that there

had not been more concerted efforts from the level of the HDWA to take steps to clarify the situation.

Trust

The variable level of trustworthiness of the stakeholders was a surprise for many. Most assumed that the delivery of patient care would be the aim of all stakeholders, and that this would be achieved in a collaborative environment of mutual trust. In the light of experience in the role, many of the respondents moved from a beginning position where they assumed that everybody was trustworthy until proven otherwise to a position where everybody was assumed to be untrustworthy until such times as they had clearly earned trust.

Relationships

All of the respondents reported surprise at the ways the DON/HSM role changed their relationships with others, both personal and professional. Rather than a relatively small number of professional nursing colleagues, they now had to develop a network across a wide variety of organisations and within the health care system of Western Australia. Most were surprised by the way in which the role changed their social life as they found that they were unable to maintain the same personal relationships with staff and community members. Those in group 2 felt this most acutely.

Most, however, were surprised by the way in which their personal relationships confused rather than clarified their understanding of their self-identity. They found that they were relating to others as either the DON or the HSM but rarely as the DON/HSM. At a time when they were trying to adjust their self-identity in the context of the new role, their social interactions tended to further confuse rather than clarify the their perceptions of self.

Strategic focus

One of the biggest surprises that most respondents encountered in the role was the need to shift from the short-term focus characteristic of clinical practice to a focus that was both wider and longer and more strategic in orientation. The surprise lay not only in the need for this change in focus but how difficult the change was. Many found that the numerous factors and influences that needed to be integrated into strategic thinking forced them to

view the world in a quite different way. Many complained that this process gave them a *sore brain.*

Multiple tasks

In clinical practice, tasks are well understood and often follow previously defined protocols. Even in times of high patient workload the questions related more to how to fit the required tasks within the available time rather than what needed to be done. Priorities were clearly established according to patient needs. Decision making took place within a framework of a professional education and legal requirements for practice. All the respondents expressed surprise about the complex and unpredictable nature of management tasks and the difficulties of management decision making within a milieu of conflicting priorities with few guidelines. The structure of tasks within the context of clinical practice did not exist in the management component of the role. Although the management component of the role required the completion of tasks such as the submission of documentation within a prescribed time frame, that was only one aspect of the management role. That the management component of the role, and hence the clinician manager role as a whole, was a constantly expanding set of multiple tasks was a surprise to all.

Role conflict

The conflicting demands of the elements of the role was a recurrent theme in this research. Although many respondents did not expect there to be a conflict, especially between the clinical and management components of their role, experience in the role suggested otherwise. Many spoke of how they had tried to maintain their clinical practice and that it was only in the face of increasing management responsibilities that they reluctantly made the decision to relinquish large sections of that role. Nevertheless, a persistent notion was that of the imperative of the clinical emergency and how it impacted on the ability to complete planned management tasks.

The ongoing nature of the conflict between the clinical and management role was a surprise for many. Resolution of that conflict proved problematic. There were no guidelines for how this conflict could be resolved, and most respondents made individual choices based on

personal preferences and their own interpretation of how best to meet the demands of the role. An optimal conflict-resolution strategy did not appear to be forthcoming.

Focus on clinical practice detracted from the management component of the role. Many felt that the management component of the role was a priority, supporting the view that without a well managed health service, clinical practice would be compromised. Alternatively, focus on the management element of the role led to an attrition of clinical skills, resulting in a loss of credibility with the nursing staff and erosion of the clinical leadership role. Loss of clinical skills also limited employment alternatives — an issue that many, especially those in group 3, considered important. Role conflict was a persistent feature of the role.

The surprises discussed are the principal areas of concern suggested by the data. They were experienced by some respondents more than others, but all the surprises integrated into a set of circumstances that those taking on the role did not expect.

In summary, the surprise that most experienced the respondents was that the role that they had undertaken was larger, busier, more complex and more demanding of the individual's personal and professional resources than they had ever imagined.

8.2.3 Cues for sensemaking

The attention to cues for the sensemaking processes in the clinician manager role was mediated by the influence of both structural elements and personal elements. The structural elements, created by and contributed to by the stakeholders, were the perceptions of the trustworthiness of the stakeholders, the political behaviour that characterised relationships with the stakeholders and the role stress that was a feature of the role. The personal elements, characteristics of those in the role that mediated attention to salient cues, were the experience of role strain, perceptions of self-efficacy and commitment to the sensemaking process.

This is supported by the following observations.

Models of work–role transitions, such as those proposed by Nicholson (1984) and discussed in Chapter 3, contributed limited understanding of the role of the DON/HSM. The data from this research supports George (1993) and Bretz and Judge (1994) who argued that transitions were too heterogeneous and too dependent on context to be captured by a single generic model. Similarly, the literature on person–organisational fit — see, for example, Ashford and Taylor (1990) — offered limited assistance. This approach examined the congruence between the norms and values of the organisation and the norms of the individual (Taylor and Giannantonio, 1993). The underlying assumption was that the norms and values of the organisation are known and are consistently expressed. This was not the case in this research.

Inherent in all the literature related to newcomer socialisation, workplace transitions and person–organisational fit was the implication that the organisation had a script to which the newcomer was encouraged to conform; i.e. that there was a "right" way of doing things. It was the role of the individual to discover this right way and the role of the organisation to persuade the individual in that direction. Although it was proposed that the individual had the discretion to mould a job according to their own values, it was implied that this moulding should be within limits of tolerance defined by the organisation.

One of the recurrent themes in this research was that the DON/HSMs in the clinician manager role did not have clear organisational expectations to which to conform. It was not even clear to the respondents to which organisation they should be committed. The health services, for which they were responsible, functioned as semi-autonomous units within the larger structure of the public health service. In the light of what could be described as a loosely coupled organisation, most perceived the HDWA and the health service for which they were responsible as connected but essentially separate organisations with different values, expectations and demands.

All saw as their first priority that their allegiance was to the health service. In their role of DON/HSM in the health service, they defined the strategic direction of the health service and shaped the organisational culture. In this way, they formed the values and norms that

shaped their own job, and in doing so, created the "right way" of doing their job. They essentially wrote the script to which they were to adhere. Salient cues were defined by the DON/HSMs in the clinician manager role subject to their own discretion and without prompting from a planned organisational-socialisation process.

The notion that underpins sensemaking is that not all alternatives are known, not all consequences are considered, and not all preferences are attended to at the same time. Instead of considering all alternatives, individuals consider only a few and do not consider all the consequences rather they focus on some and ignore others. In this way, the cues that people notice are those that are incorporated into their sensemaking. Although individuals are constrained by their ability to process all the required data and by incomplete information, circumstances may conspire to enhance the visibility of some cues and mask others. These circumstances relate to features of the environment or characteristics of the individual.

The attention to cues for the sensemaking processes in the clinician manager role was mediated by the influence of both structural elements and personal elements. The structural elements, created by and contributed to by the stakeholders, were the perceptions of the trustworthiness of the stakeholders, the political behaviour that characterised relationships with the stakeholders and the role stress that was a feature of the role. The personal elements, characteristics of those in the role that mediated attention to salient cues, were the experience of role strain, perceptions of self-efficacy and commitment to the sensemaking process.

8.2.4 Social processes

Social processes were constrained by a lack of trust and by political behaviour. The DON/HSMs, as clinician managers, relied more on conversations with self and personal attitudes and values rather than those determined by the social environment. Perceptions of self-efficacy shaped this process as personal elements influenced the degree to which their own perceptions were believed to be trustworthy.

This is supported by the following observations.

Sensemaking is influenced by the presence of others. It is in social interactions that people seek support for and validation of their explanations of events. Inherent in this process is the notion that the feedback received from others is trustworthy and reflects the others' true belief in the perceptions that they communicate. The data suggested that all respondents had inconsistent and various perceptions of the trustworthiness of their interaction with others. Levels of trust were further eroded by the political behaviour of the stakeholders as they pursued their vested interests. Interactions in such circumstances contributed to the DON/HSMs' perceptions about trustworthiness and the nature of political behaviour, but as a source of validation for the DON/HSM interpretation of the their role, such interactions were considered doubtful.

The data suggested that respondents resorted to validation from others not involved directly in the role such as spouses and friends. Most, however, depended on conversations with self to validate their sensemaking. When new in the role, most did not have developed personal schemas to facilitate their sensemaking, and relied more on intuition, "gut feeling" and hunches.

It was only with experience in the role that schemas were developed and elaborated upon. Most of these schemas, however, were developed in isolation, and rather than being validated by interaction with others, were validated by the DON/HSM's perceptions of what worked and what did not. There was much more of a reliance on the "I", the set of attitudes and values assumed by the individual, than the "me": those determined by the social environment. Perceptions of self-efficacy and self-esteem influenced this process as

these personal elements influenced the degree to which the DON/HSMs believed their own perceptions to be trustworthy.

8.2.5 Sense of identity

There was a shift in the respondent's sense of identity away from one based purely in the professional identity related to clinical practice. The direction of this shift was uncertain, and perceptions were complicated by inconsistent and conflicting feedback from stakeholders. There was support for those who suggested that the clinician manager role was a new role, rather than cosmetic changes to the old roles of clinician or health service manager.

This is supported by the following observations.

Social identification is a process by which individuals classify themselves and others into different social categories. This classification process serves the function of segmenting and ordering the social environment and enabling individuals to locate and define themselves in that social environment (Ashforth and Mael, 1989). Much of the literature supports the notion that professionals develop distinctive identities as a consequence of their occupation and the notion that the existence of a shared professional identify may be considered a key criterion for arguing that a profession exists at all (Halford and Leonard, 1999). From this point of view, professional identities are linked to particular bodies of knowledge and expertise, and not necessarily to organisational procedures or even management skills. Being a nurse, therefore, conferred a professional identity that being a manager did not. The data from this research suggested that the respondents saw themselves as nurses first, many relating how in social situations they described themselves as nurses rather than health service managers.

The data, however, reflected the notion that the respondents' sense of self in their work role was undergoing a change. There was the generally held opinion that they were moving away from an identity that rested solely in the professional identity of nursing. That they were nurses who did mainly management was a recurrent theme. The direction of that

change and its meaning, nonetheless, was creating some perplexity, and it was apparent that many did not have a clear image of themselves in the work role. The stakeholders' differing and often divergent understanding of the DON/HSM role provided ambiguous and conflicting feed back and contributed to any felt confusion. (See the discussion in section 7.5.2)

The respondents agreed that although they were fundamentally nurses, their new role was creating for them a work identity that went beyond nursing. Even so, they clearly did not identify themselves as managers instead of nurses. There was support for those researchers (for example Thorne, 1997; Willcocks, 1994; and Willmot, 1998) who suggested that the clinician manager role was a new role rather that just cosmetic changes to the old roles of clinician or health service manager.

Self identity serves as a general orientation to situations that maintain esteem and consistency (Campbell et al., 1996). The meaning that individuals attribute to information is often a function of the strength of their self-perceptions and their need for affirmation of self (Leonard et al., 1999). A confused sense of work role identity in the clinician manager role had implications for the sensemaking of the DON/HSMs as sensemaking is triggered by a failure to conform to one's self and serves to maintain a positive self-identity. The data suggested that most of the respondents are seeking an identity that reflects the job that they do but are getting very little help in this area. The general feeling was *I know I am not what I used to be, but I am not too sure what I am now.*

8.2.6 Adaptation and enactment

There was not a core of homogeneity in the adaptation to and enactment of the clinician manager role. There were diverse interpretations of the role and idiosyncratic adaptations to it. Enactment created the role in a direction that reflected individual explanations of the demands, choices and constraints of the role.

The following observations support this conclusion.

Adaptation and enactment encompass the way in which the DON/HSMs carried out their role. Adaptation refers to the way in which they interpreted the role and enactment the way in which their actions shaped the role. A useful framework for explaining these processes is that proposed by Stewart (1982a). Stewart described the manager's role in terms of demands, choices and constraints. Demands related to meeting the overall minimum criteria for performance and could be described in terms of what cannot be delegated. The data from this research suggested that many of the respondents thought of the DON/HSM role in this way and described their decisions about the actions they took in carrying out the role in these terms. It was suggested that it was easier to delegate clinical responsibilities because there was usually another registered nurse available. The management role was more difficult to delegate because others were uncomfortable with the responsibility it entailed and did not like the human resource element. It was also identified that many of the elements of the management component of the role — such as the leadership function, industrial relations, disciplinary actions and dealing with external agencies — were inappropriate to delegate.

In Stewart's (1982a) framework, constraints relate to issues such as resource limitations, legal and union constraints, physical constraints, the extent to which the work of the organisation is defined and the attitudes of others to that work. From this point of view, the constraints of the DON/HSM role were many. There was a fixed budget with few discretionary funds. Many of the activities of the health service were constrained by Acts of Parliament at both a state and a federal level — e.g. the *Nurses Act*, the *Medical Act* and the *Hospitals Act* — as well as the reporting requirements of many government departments. Physical constraints related to the rural environment, some of which contributed to the ability of the health service to attract and retain appropriate numbers of staff with the desired skill mix. Another constraint was the lack of control over the workload of the health service. The health service was required to provide care to all who presented, and for this reason, the workload could fluctuate considerably and in an unpredictable manner. DON/HSMs in all health services had to cope with these constraints.

Although the function of the health service was clearly understood by all stakeholders to be the delivery of health care to a defined population, there were varying degrees of consensus among stakeholders and between health services on how this should be done, by whom and according to whose priorities. Disagreement among the stakeholders was a serious constraint for the DON/HSM as it encouraged political behaviour, eroded the levels of trust felt and further contributed to the role stress.

It is important to recognise that not all DON/HSMs were constrained by the dynamics of the relationships between the stakeholders. In some health services where conflict levels were high, the degree of constraints was correspondingly high. In other health services, the levels of conflict were not as problematic. Thus the influence of the attitudes of the stakeholders was a constraint on the development of the DON/HSM role in an inconsistent, dynamic and unpredictable way.

Stewart (1982a) described choices as decisions of how the work is done and what work is done. A major determinant of how the work is done is the extent to which the job is defined. It is in this area that the job of the clinician manager presented so many problems to the incumbent. In order to make decisions, a clear understanding of the role is required, and this implies the need for successful sensemaking. Figure 7.6 shows how demands, constraints and choices vary.

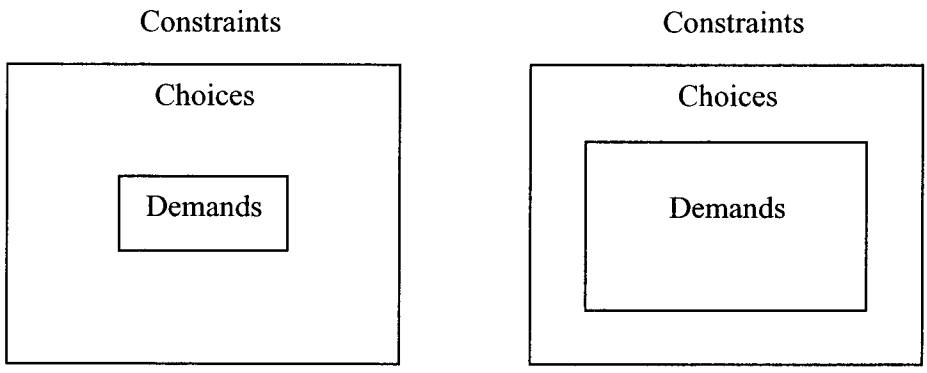

Figure 8.1: Differences in demands, constraints and choices (adapted from Stewart, 1982b)

The data suggested that some respondents saw the demands of the job (i.e. those elements that could not be delegated to others) as the biggest component of the job. Others saw that they had choices within the job and could and did exercise a considerable degree of discretion in how the job would be carried out. How, within the context of a clinician manager role the incumbents resolved the inherent conflict between the demands of clinical practice and carrying out the management component of the role showed considerable variation between the respondents. The clinical component of the role and how this interfaced with other role demands was an unresolved area for most respondents. The imperative of clinical demands and DON/HSMs uncertain role in meeting these demands impelled most respondents to deal with their clinical role in a reactive manner. They would step in when there was no other choice. Nevertheless, clinical practice was an important part of their role, and the clinical credibility of the DON/HSM was seen as an essential element in leadership and maintaining morale in the health service staff.

The sensemaking processes of the DON/HSM became an imperative as they tried to maintain plausible explanations for the ongoing stream of events and then take appropriate action in the light of these explanations. It was the actions that the DON/HSMs took that are creating the role of the clinician manager.

8.2.7 Model linking the clinician manager to the sensemaking process

The model developed to explain the data in this research is illustrated in Figure 7.1.

The discussion and conclusions in this chapter have supported the premises of the model. The structure in which the clinician manager role of the DON/HSM role was enacted embraced all stakeholders in the role including those internal to the health service, those external to it and those with boundary-spanning positions. The sensemaking process of the DON/HSMs was mediated by their interaction with the stakeholders and was influence by the DON/HSMs' perceptions of the trustworthiness of the stakeholders, the political behaviour that characterised interactions and role stress — particularly role conflict, role ambiguity and role strain.

The sensemaking of the DON/HSMs in the clinician manager role was further mediated by the personal characteristics of the DON/HSMs. The personal characteristics most salient were the experience of role strain, perceptions of self-efficacy and a commitment to the sensemaking process. These influences interacted to mediate the sensemaking process. Sensemaking was proposed to have seven properties: social context, personal identity, retrospect, salient cues, ongoing project, plausibility and enactment (Weick, 2001). The sensemaking of the DON/HSM in the clinician manager role, in turn, impacts on the interaction with the stakeholders in an interactive and ongoing cycle.

8.3 Conclusion

This research investigated the experience of those undertaking the clinician manager role — a new role for which there was little precedence, for which they had limited appropriate skills and knowledge, and in an organisational environment where there was no consensus regarding the expectations of the role.

Sensemaking, the process by which individuals ascribe meaning to the events in their environment, provided a context that directed inquiry into the experience of developing the new role. The data suggested that existing models of work adjustment and organisational socialisation provide limited understanding of the clinician manager role. Role theory provided a useful theoretical perspective that contributed a partial explanation as role stress and role strain were shown in this research to be contributory factors in the sensemaking process.

The data supported the notion that those undertaking a clinician manager role do so with few clear ideas of what the job entailed. In addition, expectations of the role were not agreed upon by the employing organisations, and how the role should articulate with other roles within the organisational structure not readily apparent. The sensemaking processes of the DON/HSMs in the clinician manager role involved dealing with unexpected characteristics of the role in addition to the surprises that emerged from the ambiguous and complex operating environment.

This research showed that sensemaking was mediated by a number of factors that have received scant attention in the literature. Trust and political behaviour were shown to be characteristics of relationships within the organisational structure that had important consequences for the sensemaking processes of the DON/HSMs. When there was doubt about the veracity of interactions with others, the data suggested that sensemaking becomes a much more internal process. In the absence of personal schemas grounded in personal experience, individuals relied on intuition and "gut feeling", and although such responses may seem groundless they were held as more plausible explanations about "what is going on", than those formed from interactions with others. In this way, much of the sensemaking processes were conducted in isolation, with the DON/HSMs in the clinician manager role relying on their personal resources.

As an extension of this notion of the reliance on the self, perceptions of self-efficacy became an important factor in the sensemaking process. Those with high levels of self-efficacy had higher levels of trust in their own explanations and greater confidence in taking authoritative actions. The data, however, suggested another and previously unrecognised mediating factor in the sensemaking process — that of commitment to the sensemaking process itself. Conceptually, much of the sensemaking process is automatic and to a large extent unconscious. It became apparent that the complexity and ambiguity of the operating environment of the DON/HSM was such that sensemaking needed to be a conscious cognitive effort, requiring considerable investment in data gathering, reflection and decision making. Some were more prepared to make this investment than others and showed a greater commitment to the sensemaking process. This impacted on the actions they took within the role and, hence, the way the role was shaped.

This research challenged the notion that accuracy is the logical outcome of the sensemaking process. The issue of accuracy implies that there is "right answer" or "ultimate truth" that needs to be pursued. The complex interaction between the stakeholders in this research suggested that the "right answer" is a perception of the individual, influenced by vested interests, the noticing of different cues and the development of alternative plausible explanations. The "right answer" then becomes what

the individual believes and serves as a basis for action. Reality lies in the belief of the individual, and accuracy in sensemaking is an irrelevance.

In summary, the DON/HSMs in the role of the clinician manager relied on their sensemaking processes in order to explain the ambiguous nature of their practice environment and to plan actions within the context of a role that was poorly defined by the organisation. Circumstances in the environment constrained their reliance on others for validation of their explanations of events and the actions they took. Despite the recognition that actions were public and therefore irrevocable, most made these decisions based on intuition and "gut feeling" and validated these decision on the basis of perceptions of favourable or unfavourable outcomes and retrospective explanations. This process was mediated by the characteristics of the individual. The ways in which the DON/HSMs in the clinician manager role adapted to and interpreted their role was diverse, which made the role more an expression of individual preferences than a coherent part of a larger organisational structure.

8.4 Implications for policy and practice

This research supports previous findings that the role of the clinician manager is poorly understood. There is little appreciation of how the role interfaces with other roles within the structure of health service organisations, both managerial and clinical. There is also little comprehension of the personal impact of the role on the incumbents. If the clinician manager role is to be an ongoing strategy in the management of health services, the onus is on the health service organisations to develop a model of the role that explains the articulation of the clinical and management demands. There is also the need for human management practices that match the skills, knowledge and abilities of those expected to carry out the role with the demands of the job.

In addition, this research suggested that the role is a new one rather than a clinical role that involves some management. Those in the role require leaders that acknowledge the components of the role equally and works with the incumbents to integrate these components into a coherent whole that will best serve the needs of the incumbent and the

needs of the organisation. Health service organisations need to pay close attention to their organisational structures and job designs if the clinician manager is to make an efficient and effective contribution to the achievement of organisational goals.

8.5 Implications for further research

This research suggested further research into sensemaking as an organisational construct. Recommended areas of inquiry include:

- how individuals develop new roles when faced limited appropriate previous experience;
- the organisational structures and the factors within those structures that facilitate sensemaking;
- the relationship between sensemaking and performance;
- the relationship between the commitment to sensemaking and work-related constructs such as organisational commitment, job satisfaction, absenteeism and turnover;
- the sensemaking processes of the clinician manager across professional groups and in different settings; and
- the relationship between sensemaking and political behaviour, particularly between professional groups in different settings.

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Appendix 1 : Letter of Agreement to Participate

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Thank you for agreeing to be part of this research.

The research is being conducted as part of a doctoral program in the Graduate School of Business at Curtin University of Technology. The aim of the research is to gain insight into the role of DON/HSMs in rural hospitals in Western Australia.

As part of this research, you will be interviewed about your experience in the role of DON/HSM. In addition you will be asked some personal information.

Participation in the interview is voluntary. You may terminate your participation in the interview at any time.

This interview will be recorded on audiotape. It will then be transcribed verbatim into a document file so that the content may be analysed, using NVivo software. When the interview is transcribed, all names will be omitted and the file identified by a number only.

The content of the interview will remain confidential to the researcher, Janice Lewis and the transcriptions of the interviews will not be shared with any other person except that needed to meet the requirements of writing the research report. The results of the research will be reported in aggregate terms only. Any direct quotes from interviewees used in the thesis will not be identified by name, either of the person or the health service in which they are employed.

At the completion of the research, the audiotapes will be destroyed. The transcripts of the interviews will be retained in an electronic version in the archives of the School of Public Health, Curtin University of Technology for five years.

I have read the above and agree to participate

Signature..... .....

Name.....

Date.....