Graduate School of Business

The Dimensions of Efficiency and Effectiveness of Clinical Directors

in

Western Australia's Public Teaching Hospitals

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Declaration

This thesis contains no material that has been accepted for the award of any other degree or diploma in any university.

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made.

Signature: …………………………………….

Date: October 2008

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Abstract

The management of healthcare has changed dramatically over the past two decades. Such change has not just been in the way medicine is practiced, but also in the way the health dollar is spent.

Hospitals have found themselves under constant and increasing pressure to not only reduce costs in relative terms, but also at the same time, provide new and expanded services. These pressures caused hospitals worldwide to closely examine the means by which they met the demands that were placed upon them (Royal Perth Hospital, 1994a; Asay and Maciariello, 1991).

One common response was to embrace New Public Management strategies, such as devolved management. That is, to place the responsibility for managing diminishing health care resources, into the hands of those who use them the most - doctors (Chantler, 1993). To achieve this many hospitals adopted organisational structures known as clinical directorates (Chantler, 1993).

Following international trends, the clinical directorate model was adopted by all of Western Australia's public teaching hospitals in the mid 1990s. The belief was that by devolving hospital management to doctors, the clinical knowledge they possess will lead to improved clinical outcomes through the better allocation of resources.

From the perceptions of Clinical Directors, Chief Executives, Nurse Managers, Business Managers and Department Heads, this research has developed a model, termed the **C**linical **D**irector **E**fficiency and **E**ffectiveness (CD2E) model, that describes the dimensions of efficiency and effectiveness of Clinical Directors in the Western Australian public teaching hospital context.

The model proposes that there are three perceived dimensions of efficient and effective clinical directorship. They are: those that are brought to the role by doctors and governed by the health environment in which they develop **(Domain Knowledge**

and Skills), those that are learned **(Business Skills)** and those that are innate **(Personal Attributes)**. The three perceived dimensions consist of nine components. 'Domain Knowledge and Skills' comprise clinical expertise, peer influence, political expertise and environment knowledge. 'Business Skills' comprise financial management, strategic management and human resource management. 'Personal Attributes' comprise commitment and participation, and communication.

The CD2E model not only describes the perceived dimensions of efficiency and effectiveness, it also outlines those dimensions that are brought to the role of a Clinical Director by the medical profession and those areas where there are perceived deficiencies.

Whilst the final CD2E model can be used to assist in developing and selecting future Clinical Directors who are more appropriately equipped to improve healthcare delivery within Western Australia, the literature suggests that the model also has features which are common and applicable to other health environments.

Chapter 1 Introduction

1.1 Introduction

In the mid 1990s Western Australia's public teaching hospitals underwent significant structural and organisational change through the introduction of devolved management. Following international trends, semi-autonomous management units in the form of clinical directorates were established in each hospital. With the aims of improving efficiency and effectiveness in the delivery of healthcare, the executive responsibility for managing those units was devolved to doctors (Clinical Directors).

This research aims to discover the dimensions that make the doctors who take on clinical directorships, efficient and effective in their role. With particular reference to the Western Australian context, this research looks at the structural changes that have occurred within hospitals over the past decade, the roles taken on by Clinical Directors, the challenges they face and the potential barriers to their success. In developing an emergent model of Clinical Director efficiency and effectiveness, this research provides original insight into the personal experiences of Clinical Directors, Chief Executives and the directorate management teams of Western Australia's three major public teaching hospitals.

The final model is used to determine the competencies that Clinical Directors require for success, the characteristics they contribute to devolved management and those elements that require further development.

1.2 Background

The management of healthcare has changed dramatically over the past two decades. Such change has not just been in the way medicine is practiced, but also in the way the health dollar is spent.

In the early 1990s, hospitals found themselves under constant and increasing pressure to not only reduce costs in relative terms but also at the same time, to provide new

and expanded services (Allcorn, 1994). These pressures caused hospitals worldwide to examine closely the means by which they met the demands that were placed upon them (Asay and Maciariello, 1991; Royal Perth Hospital, 1994a).

Many governments looked to private sector models to find an answer. The philosophy of New Public Management offered a platform on which the delivery of public sector healthcare could be reformed.

New Public Management is the application of private sector business practices to public sector organisations. Examples of the types of business practices include: quality management, cost control, financial transparency, quasi-market mechanisms, customer satisfaction measurement, autonomous sub-units and devolved management (Hansson, 2001; Skalen, 2004).

The business values of New Public Management such as functional rationality, cost effectiveness and productivity sharply contrast with the traditional democratic values of public administration such as political democracy, public ethics and security of life and property (Skalen, 2004). However, it is the benefits of increased efficiency and effectiveness that has made New Public Management a popular ideology for public sector healthcare reform (Skalen, 2004; Vlastarakos and Nikolopoulos, 2007).

The devolution of management and the creation of semi-autonomous clinical sub-units known (for the purpose of this study) as clinical directorates was one of the obvious influences of New Public Management reforms on the public health sector. First introduced by John Hopkins Hospital in Baltimore in 1974 and later adopted by Guy's Hospital, London in 1984 (Llewellyn, 2001), the clinical directorate model has resulted in significant organisational restructuring of hospitals. Within each hospital, medical specialties or group of specialties were combined into single semi-autonomous entities, each having full budgetary and clinical decision-making authority.

Over time, this strategy of devolved management has developed a worldwide popularity among healthcare administrators, in that it is perceived to place the

responsibility for managing healthcare resources into the hands of those who use them the most. In the case of public teaching hospitals, those individuals are the hospital's doctors.

But what is the thinking behind this strategy? Why do hospital administrators believe that devolving management to doctors is the panacea for all of the financial ills that have befallen public teaching hospitals?

The healthcare management literature suggests that devolving management to doctors can produce many benefits (Disken et al, 1990; Goodier, 1994; Clinical Directorates Implementation Team, 1996). A greater clinical input into the development and prioritisation of health service strategies would be considered one of the most important advantages. Through a faster identification of changes in the healthcare environment doctors are able to assist with improvements in service planning and the speedier adoption of new strategies.

Having accurate and timely information by which to make important strategic decisions is essential for management. It is thought that through the involvement of doctors, new and more sophisticated information systems can be developed that allow the explicit evaluation of clinical work, service initiatives and the cost of care.

From a financial perspective, it is thought that bringing doctors on board as a group will result in better resource utilisation and help reduce the cost of service delivery. By devolving the ownership of budgets to doctors, it is thought that the health dollar will be spent more efficiently and effectively.

It is also believed that patient care can be better coordinated though the integration of various hospital functions. By promoting a team approach to service delivery, the barriers between professional hierarchies and other hospital groups can be broken down to significantly improve overall patient outcomes.

Communication between clinical and management groups within a hospital can also be enhanced through devolved management. By having Executive positions and

direct access to the Chief Executive, Clinical Directors are able to improve communication channels between their colleagues, other healthcare professionals and management. It is thought that improved communication between these groups can result in greater job satisfaction and higher staff morale. By introducing a sense of corporate belonging for clinicians, it is believed that staff performance is improved.

Although impressive, many of the benefits stated above are based upon an assumption. That assumption is, that when management is devolved to doctors, they will be able to provide a level of management that is equivalent to that of a professional manager.

A search of the sociology literature would suggest that this proposition is not necessarily correct. A number of sociologists believe that the concepts of management are really quite foreign to doctors (Pointer and Sanchez, 1994; Dye, 1996; Zaher, 1996; Gatrell and White, 1996). The suggested reason is that doctors think with a 'clinical mentality'. In other words, they operate from a completely different paradigm or mind-set to that of professional managers.

In addition to the cognitive issues, Clinical Directors also face a number of structural, operational, training and ethical challenges to their success. Given that the barriers to success can be high, the success of a devolved management structure is closely tied to the ability of a Clinical Director to overcome them.

1.3 Significance of the Study

The increasing demand for efficient and effective healthcare in Western Australia has seen pressure placed upon the State's public teaching hospitals in recent years. One common response throughout the public hospital system has been to embrace the strategy of devolved management. By placing the responsibility for managing healthcare resources with doctors, hospital executives hope to reverse the perceived inefficiencies of the past.

Such an approach obviously requires efficient and effective management from those doctors who are now faced with the added responsibility of clinical directorship. Despite this need, however, it would appear that little research into what makes a Clinical Director efficient and effective in an Australian context has been performed to date.

It was envisaged that this research would help to address the deficiency of knowledge that exists in this field. It was hoped that by exploring the issues surrounding the efficiency and effectiveness of Clinical Directors in their role, the development and selection of future Clinical Directors, more appropriately equipped to improve healthcare delivery within Western Australia, would be facilitated.

1.4   Structure of Thesis

This thesis comprises seven chapters. This first chapter provides a brief introduction to the topic, its context, purpose and structure.

Chapter 2 presents a critical analysis of past and present knowledge on the topic. It describes how over the past two decades, public sectors both internationally and nationally has been reformed through the introduction of New Public Management principles. The underlying concepts of New Public Management and their impact upon public sector health are summarised and critically analysed. The chapter continues with a discussion on how doctors have become more involved in healthcare management through the devolution of responsibility. The various types of organisational structures that are found in public sector hospitals are reviewed with particular attention given to clinical directorates. Their function, responsibilities, management and potential barriers to success are summarised. The chapter concludes with a look at the motivational factors and challenges that face doctors who take on clinical directorships.

The methodological approach to this study is outlined in Chapter 3. The research design and methods used in the study are commented upon. The methodological issues that are discussed in this chapter include the theoretical foundations of the research, the research paradigm and the grounded research approach. A summary of

the problem, the research question, and objectives of the study follow. The chapter continues with an outline of the assumptions that underlie the research and the criteria for ensuring its rigour. The development of the interview process, data collection and data analysis are also reviewed. The ethical issues that were considered, complete the chapter.

Chapter 4 sets the context for the research. It outlines the Australian healthcare system, especially looking at the private and public healthcare sectors, their funding and expenditure and Australia's national health scheme - Medicare. A description of the recent history of the healthcare system in Western Australia provides a setting for the research. Overviews of the three public teaching hospitals complete the chapter with particular reference to their organisational reviews and eventual organisational structures.

Data from the research are presented and discussed in Chapter 5. The findings suggest that efficient and effective clinical directorship comprises three dimensions: knowledge and skill that are contextually specific to the health domain, business skills that are learned and personal attributes that are brought to the role. Each of the three dimensions, their nine components and supporting elements are discussed in turn. An emergent model that outlines the perceived dimensions of efficiency and effectiveness of Clinical Directors completes the chapter.

Chapter 6 commences with a discussion on managerial efficiency and effectiveness in organisations with particular reference to hospitals. An emergent model, the **C**linical **D**irector **E**fficiency and **E**ffectiveness (CD2E) model is presented for discussion. The components of the model are then discussed in turn. In this chapter, the relevant literature on clinical directorship is compared and contrasted with the findings. In particular, a model that describes the dimensions of Clinical Director competence is compared with the emergent model. The chapter concludes with a discussion on the possibility of using the CD2E model to identify the skills and attributes that are perceived to be necessary for efficient and effective clinical directorship.

Chapter 7 is the concluding chapter of the thesis. It links all the key findings as presented and discussed in the previous chapters in order to address the aim of the study. This chapter presents the final model of the dimensions of Clinical Director efficiency and effectiveness. It draws conclusions about the components brought to the management role by doctors and makes comment on their development requirements. It makes recommendations on management development, mentoring and possible incentives to help improve the calibre of future Clinical Directors. The limitations of the study are acknowledged, as is its contribution to healthcare management literature. The chapter concludes with comment on the implications of this study for future research and education.

Let's start the journey with a critical analysis of the relevant literature on devolved management in healthcare…..

Chapter 2 Literature Review

2.1 Introduction

This chapter offers an overview of the literature associated with devolved healthcare management and the role of doctors in that process. It begins by introducing the concepts of New Public Management and Managerialism. It describes how through the application of these philosophies to the public health sector, doctors have become more involved in the management of healthcare. A description of the various organisational structures used in public hospitals follows, with particular emphasis given to devolved management and clinical directorates.

The responsibilities of a clinical directorate are next discussed, followed by a description of the directorate management team, their roles and responsibilities.

The chapter continues with an outline of the potential barriers to clinical directorate success and a discussion on the conflicting cognitive framework (clinical mentality) that doctors bring to management. A discussion on what motivates a doctor to move into the management field and what challenges they face completes the chapter.

2.2 New Public Management

As public administration theory has evolved over the past 150 years, management concepts such as public management, human resource management, budgeting and finance and evaluation and planning have become more prominent (Edwards, 1998).

In the early 1980s, a new generation of thinking termed New Public Management was introduced to the field. The New Public Management model is one that uses private sector innovation, resources and organisational ideas to improve the public sector.

There is no clear consensus on a precise definition of New Public Management, however, (Baird, 2004:2) outlines its major themes as being:

- The adoption of private sector management practice in the public sector.
- The rigid separation of policy-making and service delivery.
- An emphasis on efficiency.
- A movement away from input controls, rules and procedures.
- The use of output measurements and performance targets.
- A preference for private ownership, contestable provision and contracting out of public services.
- The devolution of management control and,
- Improved reporting and monitoring mechanisms.

Since the 1970s, governments throughout the world have sought the introduction of management reforms to curb public sector spending (Parker et al, 2000). The changes that were implemented can be broadly divided into two major facets – privatisation and management structures and processes designed to increase efficiency/effectiveness (Lawler and Hearn, 1995).

The privatisation of public sector authorities has been an increasing worldwide trend in both developed and developing economies over the past few decades (Anderson et al, 2002). In Britain for example, successive Conservative governments of the 1980s and 90s privatised authorities such as bus services, telecommunications and public housing (Lawler and Hearne, 1995). Their aim was to replace the nation's "welfare culture", where welfare services are provided by the State, with an "enterprise culture", where the free market provides services according to demand (Lawler and Hearne, 1995:7). The same theme was echoed in the USA, Australia and many other OECD nations during this era.

Interestingly, Lawler and Hearn (1995) point out those public sector agencies that perform a pure welfare function such as health services have been exempt from privatisation. Rather, these organisations have been subjected to demands of improved efficiency and effectiveness through the implementation of New Public Management principles.

Whilst bureaucracy and legislation bind the traditional public sector model, the New Public Management model is based upon the free market. As a result, the public sector paradigm shifts from one that has an administrative focus to one that is based upon results (Anderson et al, 2002).

The New Public Management model also tries to de-politicise policy making by reducing the State's role in service delivery (Anderson et al, 2002; Gallop, 2006). In relying upon market forces, the model is viewed as having better economic and social outcomes than the traditional public administration model (Anderson et al, 2002).

The incorporation of commercial principles into the public sector has meant that concepts such as benchmarking, comparability, contestability, choice and competition have now become part of the public sector vocabulary (Gallop, 2006).

Managers are now required to be more accountable for their actions, budgets are carefully scrutinised and cost-cutting measures implemented wherever possible. The New Public Management model is designed to give managers the freedom to manage, to generate results and improve organisational performance (Gallop, 2006; O'Donnell et al, 1999). They are able to make hard economic decisions that are evidence based and apolitical in nature (Van Gramberg and Teicher, 2000).

The drive for efficiency and effectiveness has seen management principles such as quality management, flexibility, service delivery, measurement and outputs become embedded in the work practises of public sector organisations (Besoda, 2007; Flanagan and Spurgeon, 1996). In fact, it has been claimed the public sector has been so transformed, that cost consciousness has become a pervasive culture (Flanagan and Spurgeon, 1996).

Being an outcomes-based model, New Public Management has seen goals, targets and key performance indicators introduced into the public sector. With these tools, performance can be quantitatively measured and the level of success in service delivery accurately determined (O'Donnell et al, 1999).

This emphasis on a private sector style of management has encouraged the growth of managerialism in the public sector. The term 'managerialism' makes the presumption that…

"… from a management perspective, the public and private sectors are not dissimilar and therefore should be managed on the same basis."

Hoque and Moll (2001:305)

As a consequence, private sector management practices such as business plans, mission statements and strategic plans have been widely promoted and incorporated into the public sector business culture (Hoque and Moll, 2001).

Many of New Public Management's proponents have argued that the model also provides a reward for workers. Such rewards can take the form of training, multi-skilling and the introduction of new technology (O'Donnell et al, 1999). Despite this argument, adoption of the New Public Management model by the Australian public sector has seen extensive decentralisation and rationalisation of the workforce. Labour reforms such as decentralised wage bargaining, individual employment contracts, performance-based pay and downsizing have been implemented mostly to the disadvantage of the workforce (O'Donnell et al, 1999). O'Donnell et al (1999:2) suggest that:

"… despite the optimistic expectations of workplace reform, the reality of workplace change for many public service workers has involved greater workloads, increased job-related stress and reduced job security."

With this in mind, it has been suggested that New Public Management reforms can be counter-productive by promoting conflict, distrust and dissatisfaction within the workplace (Currie, 1996; O'Donnell et al, 1999). Notably, these phenomena have been widely evidenced in the public sector and in particular among professional workers (Lewis, 2004; Mickan and Boyce, 2006).

Causer and Exworthy (1999:2) report that…

> "… many writers interpret Managerialism as a strategic weapon with which to curb the powers of overly independent professionals."

It appears that if considered a 'weapon', managerialism has hit its target. Hallier and Forbes (2005) suggest that over the past decade there has been a widespread decline in the status and autonomy of professional workers. Much of the decline, they believe, has been as a consequence of the imposition of performance monitoring and organisational priorities upon professionals (Hallier and Forbes, 2005). As Walby and Greenwell (1994:70) in Learmonth (1997:217) suggest, in the healthcare sector:

> "Quality indicators, outcome targets, performance review, peer review and so on could be used to improve the service to patients, but in the context of fierce 'cost containment' they are as likely to be used to squeeze workers."

With an emphasis on outcomes and performance, Managerialism has placed healthcare professionals in the unenviable position of having to justify their clinical practice (Lewis, 2004).

According to Kitchener (2000), the introduction of evidence-based medicine to clinical practice has further weakened the argument for clinical autonomy. Evidence-based medicine directs both clinical practice and healthcare policy making to be based upon empirical evidence and rational decisions. Being a policy-driven approach, evidence-based medicine somewhat diminishes the control that professional groups have over the traditional peer-review process. Despite the fact that managers should be able to use evidence-based clinical data to direct clinical practice, Kitchener (2000) suggests that the powerful medical lobby still strives to protect its autonomy. This is achieved by ensuring that practice developments are, for the most part, internally driven rather than externally imposed.

This trend, towards "proletarianising" the professional workforce has been strongly resisted within the public healthcare sector (Thorne, 2002:14). Lewis (2004:113) suggests that:

> "While some may see this as a positive outcome, many healthcare professionals see it as a direct attack on their professional status. The view that Managerialism is undermining professionalism is widely held and greatly resented."

The inherent tension between the professional values of health professionals and the new managerial demands for improved efficiency, cost control and resource allocation have highlighted the reluctance of medical professionals to adopt management values and priorities (Hallier and Forbes, 2005). It has been suggested that the introduction of market-oriented policies has eroded the standing of the medical profession through the curtailing of clinical autonomy (Nowak and Bickley, 2005).

Such "deprofessionalisation" of health professionals has had a significant impact upon the relationship between management and healthcare professionals (Thorne, 2002:14). Stoelwinder et al (2006:307) suggest that although…

> "…one aim may have been to pull health professionals into line…it has also destabilised the health system. It has made health professionals very suspicious of managerially inspired motivation designed to make things better for the patient."

One strategy by which health professionals have contested managerialism, has been for them to encapsulate their professional bodies within their organisation. It has been suggested that rather than being accepting of management change, these groups tend to be inward looking and defensively organised. As such, they are able to defend themselves vertically against senior management and horizontally against other professional bodies within their organisation (Ackroyd, 1996).

The prerogative of professional autonomy has also assisted health professionals to resist the regulation of work practices that is brought about by managerialism. According to Hallier and Forbes (2005:47):

> "…some professional groups have continued to hold out for the right to professional autonomy and to determine task priorities even in the face of increases in the power of general management."

The mantle of professional autonomy, based upon judgement, accountability and trust (Nowak and Bickley, 2005) has allowed health professionals to treat patients in the most effective rather than efficient manner (Lawler and Hearne, 1995). In other words, cost is not necessarily a consideration in the effective treatment of patients. As was reported in Elliot's study of clinicians dealing with cancer patients:

> "A good clinician should treat every individual patient as an individual and give him the best treatment that's around."

> Fisher and Best (1995:49)

Unfortunately, 'the best treatment that's around' can come at a prohibitive cost. As put by Kowalczyk (2002:120):

> "The introduction of public management in the health service presented a challenge to the medical profession. Clinical judgement was no longer the only arbiter of decisions as the need to ration services took pre-eminence"

With what appears to be a mounting array of obstacles from health professionals and their organisations being put in the way of the New Public Management, one must consider how senior healthcare managers have looked to overcome them. According to Kirkpatrick et al (2007), the past assumption that clinical professions' natural response is to resist or stifle change has recently been challenged. Depending on the

context, medical professions can dominate or capture management to advance their own collective interests.

2.3   Doctors' Involvement in Healthcare Management

"The nearer that the management process gets to the patient, the more important it becomes for doctors to be looked upon as the natural managers."

(Griffiths, 1983 in Simpson (1994:1507)

The increased involvement of doctors in management has been seen as a significant change in the way healthcare is administered. It is no longer accepted that a doctor's management role is to offer advice through representative structures. There is now an expectation that doctors will be as accountable for the performance of their hospital as its managers are (Sang, 1993). According to Sang (1993), doctors are aware that they must now compete for finite resources. They have come to understand the concept of opportunity costs and how they must play a leading role in demonstrating the effectiveness of their interventions in competition for scarce resources.

Educated to be individual experts and independent decision-makers, doctors now find themselves thrust into group problem-solving and collaborative decision making teams (Farrell and Robins, 1993). The environment has changed so much, according to Farrell and Robins (1993:40), that those who once operated as "captains of their ship" must now employ new management skills to inspire shared vision and facilitate consensus among their colleagues. Whereas once they believed management was enacting hierarchical control and professional authority through charisma and seniority, they now need to develop a more co-operative management style (Dawson et al, 1995).

A contributing factor to the introduction of doctors to management has been the unique attributes that they can bring to the management role. Simpson (1994) suggests that the traditional perspective and skills of doctors can serve as an effective

framework on which to base their management practices. Observation, analysis, diagnosis, problem solving and action planning can all be applied to organisational-wide rather than patient focussed issues. Similarly, Zaher (1996) believes that some of the skills and abilities that doctors possess can be transferred to the managerial setting. For example, doctors:

- Learn to listen to people and interpret non-verbal clues.
- Are analytical and are able to assess complex interdependent conditions.
- Can consider multiple problems concurrently.
- Are lateral thinkers who can integrate numerous piece of different information.
- Are creative and resourceful.

Zaher (1996:13)

The argument for the involvement of doctors in management is also supported from a purely operational perspective. It has long been recognised that the great majority of costs generated within a hospital are as a consequence of the clinical practices of doctors (Dye, 1996; Goodier, 1994; Boyce, 1994; Hancock, 1991). It therefore follows, that decision-making in respect to the allocation of finite resources, should involve clinical staff (Goodier, 1994; Boyce, 1994).

In the past, doctors have been held accountable only for the treatment they provide to their patients (Dye, 1996). However, Hancock (1991) argues that it is now generally accepted that management strategies aimed at reducing cost factors such as the length of stay in hospital or the use of ancillary services, are more likely to succeed when directed by a manager who is a doctor. Fitzgerald (1994:37) agrees. She believes that:

> "It is virtually impossible to imagine how managers, in isolation, could carry out the tasks required to specify the type, form, quality standards and volumes of a specific medical service without the active involvement of clinical specialists."

The past's lack of transparency between clinical and managerial functions has been accompanied by mutual misunderstanding between managers and doctors (Llewellyn, 2001). Doctors, according to Llewellyn (2001:595), have differentiated themselves from both executive and operational management by forming "encapsulated enclaves". These enclaves meant that managers and doctors ended up working with differing mindsets. The narrow focus of doctors and the lack of clinical understanding by managers resulted in ineffective healthcare (Llewellyn, 2001).

Kaissi (2005) points out that integration rather than segregation of doctors' involvement in the management structure of hospitals is a more effective way for hospitals to cope with the changing environment they face. Collaboration between managers and doctors in cross-boundary tasks such as budgeting, rationing, performance review and risk management is essential for the success of healthcare organisations (Llewellyn, 2001). The integration of doctors into management, according to Kaissi (2005), results in frequent, open and honest communication, mutual decision-making, and timely, effective and collaborative actions.

The nature and complexity of hospital staff has also played a role in introducing doctors to management. Hospitals are not simple hierarchical structures that are easily managed. Operating as "professional bureaucracies" they differ from the majority of service or production orientated organisations in that they employ highly skilled and intensively trained professionals. Rather than autocratic management, these professional groups require management through support, co-ordination and facilitation (Simpson, 1994:1507). As such, it requires a manager who, as Simpson (1994:1507) describes, "is able to lead from the side". That is, someone who is able to pull teams of decentralised professionals together to form an effective corporate whole.

Simpson (1994) believes that doctors are the ones who can perform this function and that the involvement of doctors in management formalises and makes explicit the need for professional involvement in the management of professional groups.

For devolved clinical management to succeed, doctors must be employed in a structural environment that encourages and supports their involvement.

2.4   Organisational Designs in Healthcare

Although the literature describes a number of structural variants and hybrids, the two types of organisational designs most commonly described in the healthcare field are the functional and directorate structures.

2.4.1   Functional Structure

For decades, hospitals were managed along functional lines. A functional organisational structure is one in which departments are grouped according to they type of work they do. In other words, they are grouped together if they perform the same function or task. The number of departments is determined by the size of the organisation (Maddern et al, 2006). An illustration of a functional organisational design is shown below.
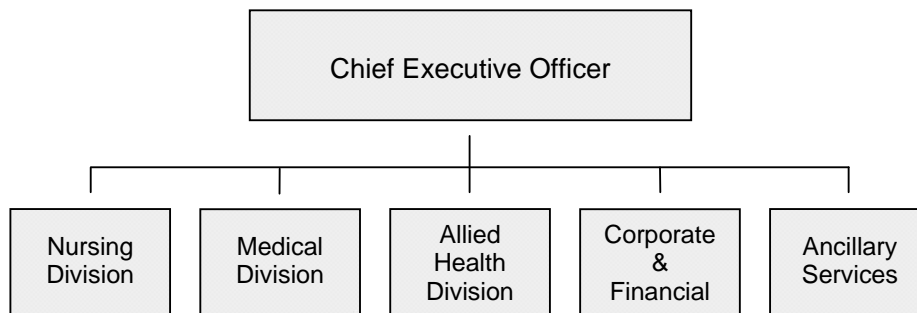
Figure 2.1   Functional Organisational Design
Source: Maddern et al (2006:285)

This design is considered a traditional-professional structure and has historically been used in hospital environments (Maddern et al, 2006; Braithwaite et al, 2006). The management hierarchy commonly includes the three broad functional areas of administration, nursing and medicine through Directorships of Corporate Services, Nursing and Clinical Services (Braithwaite et al, 2006). Other areas such as allied health and ancillary services can also be represented on the Executive.

In hospitals, functional organisational structure can be based upon functions required within the hospital. For example, the engineering, supply and radiology functions of the hospital would be grouped into the engineering, supply and radiology departments. Functions are also grouped according to profession. Therefore in the functional organisational structure, one would find professions such as nursing and physiotherapy professions grouped into nursing and physiotherapy departments (Charns, 1986).

The span of control in a functional design extends from the Chief Executive Officer through positions of senior and middle management (in charge of departments, clinical units and wards) to the individual employees (Emberton, 2006; Braithwaite et al, 2006). With the chain of command being vertical and decision-making being central, this form of structure attaches power to status (Maddern et al, 2006; Clark and Copcutt, 1997). It relies on routine, explicit rules and well-documented procedures to create efficiency (Clark and Copcutt, 1997).

Charns (1986) believes that the functional design is popular among traditional administrators in that it separates administrative from patient care responsibility. The Chief Executive is responsible for functions such as finance, personnel, supply, engineering and such like, whilst the Directors of Clinical Services and Nursing remain autonomously responsible for patient care.

According to Shortell and Kaluzny (2000), a functional design is best suited to organisations that have only a small number of products, services or goals, are relatively stable with few changes taking place, and have limited interaction with other organisations.

The literature suggests that this traditional structure has a number of beneficial characteristics. They include:

- The support of economies of scale due to the groupings of like disciplines or the pooling of resources such as personnel and equipment.
- A focus on cost and quality at the departmental level.

- Ease of performance monitoring by functional groups.

- A greater efficiency of service through the repetition and refinement of tasks.

- The advancement of professional development, interaction and support.

- The development of clear career pathways through the organisation.

(Charns, 1986; Goodier, 1994; Maddern et al, 2006)

These benefits, however, need to be considered in conjunction with the limitations they place in the delivery of healthcare. One well-recognised disadvantage is the natural tendency for such structures to lead to the fragmentation of patient care (Clinical Directorates Implementation Team, 1996). A silo mentality develops in which managers are held accountable for the performance of their individual departments rather than the performance and growth of service lines such as cardiac or cancer services (ECG Management Consultants, 2007).

In this structure, Dawson et al (1995) comment, doctors work within their own specialty and choose whether or not they wish to co-operate with other medical consultants. Collaboration does tend to occur; however, the level of managerial, corporate and collegial involvement they choose to deal with is usually optional (Dawson et al, 1995). Kennedy (1990) points out that under a functional structure, doctors' contribution to management is somewhat tenuous. Their involvement is commonly through Medical Advisory Committees or Craft groups that often fail to implement actions as they act purely in an advisory form.

From a hierarchical and bureaucratic perspective, hospitals are claimed to be unique. Unlike management in the majority of organisations, hospital management has no control of work structure, productivity and outcomes. In reality, clinical autonomy and professional responsibility prevent hospital management from having control over medical processes and decision-making (Braithwaite, Vining and Lazarus, 1994). Administrators and doctors tend to be at cross-purposes with administrators seeking to contain costs and doctors wanting to optimise patient care and outcomes (Maddern et al, 2006). As Braithwaite, Vining and Lazarus (1994:566) point out:

"The dichotomy of responsibility between clinicians undertaking the care and managing the patient and hospital executives doing the financial and general management proved to be a substantial barrier between the two groups."

In some cases, according to Braithwaite, Vining and Lazarus (1994), the gulf is so wide that there is little consensus or common purpose. Other disadvantages include:

- The promotion of territorialism by both function and profession.
- The restriction of authority for major service decisions to only a few individuals.
- The centralising of decision-making without adequate information and communication.
- The creation of indecision and lack of cohesion in organisational decision-making.
- The slowing action taking due to the rigidity and centralisation of decision-making at the top.
- The focusing of CEO and executive attention upon day-to-day management rather than strategic issues.
- The inhibition of flexibility to respond to external pressures.
- Difficulties in the formulation of long-term service plans.
- The promotion of ineffective committees and unnecessary bureaucracy.
- The encouragement of departmental processes to develop independently.
- The promotion of a low level of organisational commitment, due to the lack of ownership of decisions.
- Difficulties in implementing service line strategies that bridge multiple departments.
- Lack of accountability to achieve organisational-wide objectives.
- Little incentive for cost containment as financial control is held centrally.

(Royal Perth Hospital, 1994c; Adelaide Women's and Children's Hospital, 1994; Clinical Directorates Implementation Team, 1996; Clark and Copcutt, 2006; Maddern et al, 2006)

Arthur (1994) suggests that the centralisation of management in hospitals also leads to a number of other undesirable features. They include:

- An excessive number of job classifications as a result of overspecialisation.
- A tendency towards poor collaboration and communication through the compartmentalisation of functional groups.
- The over or inappropriate utilisation of limited resources.
- Excessive management overheads as a consequence of high supervisor-to-staff ratios.
- Department-centred rather than customer-focused services.

2.4.2   Devolved Management Structure

Maddern et al (2006) believe that as healthcare organisations get larger, they become too unwieldy to manage in a bureaucratic, hierarchical form. As a consequence, devolved management structures have become popular in recent decades.

Lazarevic (1994) describes the importance of extensive consultation with all key stakeholders when considering implementing a devolved management structure. This includes clinical staff, administrative staff and industrial representatives. Consultation allows staff the opportunity to be involved in choosing the preferred organisational model and composition of the clinical management teams. The success or failure of the consultative process, suggests Lazarevic (1994), is contingent on the acceptance of clinicians in their new management role. She believes:

> "Their understanding of the reasons for implementation of organisational change, their active participation in determining the organisational model to be implemented, and their continued commitment to make it work, are all critical."

(Lazarevic, 1994:19)

According to Lazarevic (1994) the most important elements in choosing an organisational design are the hospital's needs, the management expertise of the clinical staff and the corporate ethos.

The devolved management designs most commonly introduced have been based upon a model known as a clinical directorate model. This model was first introduced in 1974 by the John Hopkins Hospital in Baltimore and later adopted by the Guy's Hospital, London in 1984 (Llewellyn, 2001). The clinical directorate model can take two forms. They are: a divisional form or a product/service-line form (Boyce, 1994; Clinton and Scheiwe, 1995; Braithwaite and Westbrook, 2004; Braithwaite et al, 2006).

2.4.2.1 Divisional Form

The first form, termed a divisional structure, groups services along traditional medical lines (Shortell and Kaluzny, 2000). For example, a divisional structure commonly consists of Divisions of Medicine and Surgery (Braithwaite et al, 2006; Maddern et al, 2006). The introduction of allied health divisions, as a third functional group was proposed in the early 1990, but never garnered much support (Catchlove, 1991). As shown by the following figure, each division is made up of a broad range of disciplines that is defined by their particular speciality.
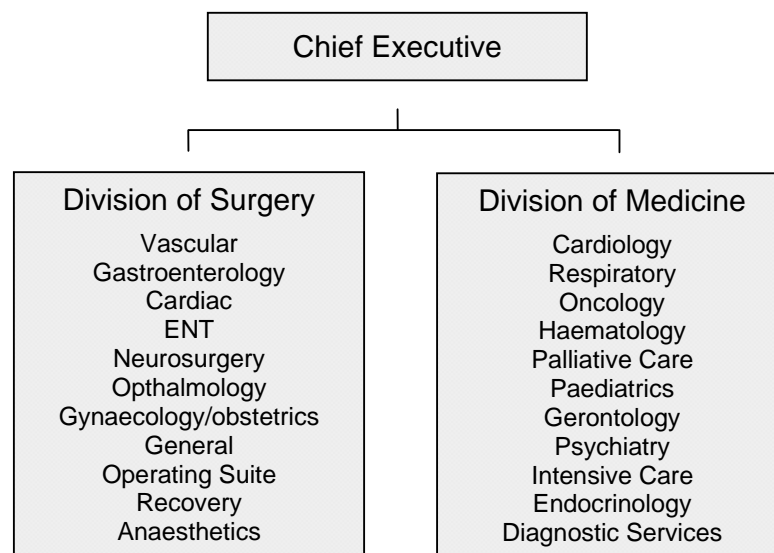
Figure 2.2   Divisional Organisational Design
Adapted from: Maddern et al (2006: 286)

In the late 1980s and early 1990s, many hospitals began to question the appropriateness of divisional groupings. As a result, they began to cross the traditional medical boundaries and align clinical units according to 'product' or 'service' lines such as cancer services, cardiac services and diagnostic services (Shortell and Kaluzny, 2000).

2.4.2.2 Product/Service-Line Form

According to MacStravic (1986) it has long been suggested that hospitals can be best understood and even administrated along product rather than functional lines.

The concept of product line administration refers to…

> "… the assignment of responsibility for individual products, or for families of related products, to specified managers."

(Charns, 1986:396)

In other words, a designated manager is delegated the total responsibility for the active administration of a nominated product including aspects such as quality, cost and responsiveness to clients (Charns, 1986).

The introduction of funding by way of diagnosis related groupings (DRG) in the 1980s forced hospitals to think in terms of products rather than function (MacStravic, 1986; Manning, 1987). Instead of hospital funding being based upon the allocated costs from all functional departments, payments under the DRG system are determined according to the number of patients in a specific diagnostic or treatment category.

When it comes to healthcare, the definition of a hospital's product is not that straight forward. MacStravic (1986:36) defines a product line as…

> "… a set of products that when planned, managed, or marketed as a group yields some advantage over being treated as isolated individuals."

Whilst it could be considered that a hospital's product is the services it provides, it is commonly accepted that a hospital's final product is a treated patient (Charns, 1986). Therefore, in the hospital setting, product-line administration places the responsibility for managing groups of 'treated patients', for example cardiac patients, with specific managers (Charns, 1986).

Simpson and Clayton (1991) report that some critics have considered product line administration unworkable in the human services area due to its manufacturing industry heritage. Others, according to Simpson and Clayton (1991), argue it is unethical to compare the marketing and profitability of a manufactured item with the life-sustaining services provided by a hospital. Perhaps in response to these reactions, Charns and Smith Tewkbury (1991) describe how hospitals that have introduced product line administration sometimes purposely avoided using the term 'product' due to its negative connotations in healthcare. Rather, they use the term 'service-line' to more accurately describe the service orientation of the health industry. Clancy (2002:25) for example, uses the term "service" in his description of line management models. He defines the service line model as one that…

> "… integrates multiple departments, functions or services that relate
> to a particular clinical specialty or subspecialty."

MacStravic (1986) explains that the extent of service line administration can be expressed in terms of its width and depth. Width is a horizontal dimension that describes the number of different service lines a hospital offers. For example, a hospital may offer services to do with cardiac medicine, cancer, obstetrics, psychiatry and so on. The depth of a service line is a vertical dimension that describes how many modes of service are contained within each category. For example, the cardiac medicine service mentioned previously may contain cardiac testing services, percutaneous cardiac intervention, outpatient clinics and cardiac surgery.

Service-line administration according to MacStravic (1986) contains three basic elements: planning, management and marketing. Service-line planning involves examining, monitoring and forecasting the hospital's activities in terms of its services. These activities determine what services to offer, how and to whom.

Service-line management focuses mainly on cost control. It involves the organising, directing and controlling of the hospital's operations along the various service-line groups. For example the admitting and discharge procedures for cardiac compared to obstetric patients may be different. Service-line marketing looks mostly at the mix and volume of staff and patients. MacStravic (1986) argues costs are difficult to control if these elements are not matched.

According to Simpson and Clayton (1991), service-line administration requires a budget process that can be flexible and align with the service's strategic objectives. It must also be supported by robust cost accounting system that can be interrogated to:

- Determine a service-line's contribution to margin.
- Analyse resource consumption by acuity, severity and disease within each line.
- Compare the treatment patterns of doctors treating similar patients and,
- Analyse long-term utilisation trends.

Simpson and Clayton (1991:37)

Litch (2007) believes that service-line administration can provide a platform for decision-making that inevitably leads to clinical synergies. Long-term benefits according to Litch (2007:14) include:

- An alignment of strategy that connects the hospital and doctors as partners.
- Creates a continuum of care that achieves measurable outcomes and,
- Aligns resourcing with performance and outcomes.

Despite the benefits, Manning (1987) believes that service-line administration should not be regarded as a cure for all the ills currently affecting healthcare management. He believes that to be successful, service-line administration requires three important areas to be addressed:

- The implementation of adequate management and information systems.
- Appropriate planning and implementation and,
- Management control over doctor activities.

According to Clancy (2002), the service-line model attempts to break down the barriers that are usually found in traditional hospital designs and clusters staff by clinical specialty rather than function. This model provides a foundation for the clinical directorate design.

2.5   The Clinical Directorate

The concept of a clinical directorate involves the grouping together of clinical units of similar service focus to form a major service unit. Capewell (1992:441) defines one as:

> "...a managerial sub unit within a hospital or unit, headed by a Clinical Director, a clinician who has budgetary control for the whole directorate, including all staff, drugs, equipment and supplies. He or she is managerially accountable for the utilisation of the resources allocated and for the proper functioning of the directorate."

The introduction of product/service line management and the directorate model saw operating responsibilities and financial accountability for services shifted from centralised management to clinical groups (Clinton and Scheiwe, 1995; Chantler, 1993; Heyssel et al, 1984).

Each clinical directorate is accountable for all direct costs associated with the unit's operation. In some models, this can include services from other departments such as radiology, pathology, housekeeping or engineering. Indirect costs such as administration, billing, security and so on, are in some models also allocated to each directorate (Heyssel et al, 1984).

The directorates are required to operate according to hospital policy on global matters such as organisational goals, capital allocation, human resource management, purchasing and such like. Various cross-directorate committees are usually established to manage hospital-wide policies (Heyssel et al, 1984). Typically with this form of organisational structure:

- The corporate and functional levels of hospital management are separate.

- Management responsibility, including financial decisions, is devolved to the functional unit level.

- Functional units are organised along the lines of medical specialties.

- A doctor who is supported by a Nurse Manager and Business Manager heads each functional unit.

(Heyssel et al, 1984; Clinton and Scheiwe, 1995)

Directorate structures were first introduced to Australia by St Vincent's Hospital in Sydney in 1989 (Australian Nursing Federation, 1991; Braithwaite et al 2006).

All four major public teaching hospitals in Western Australia, namely, Royal Perth, Sir Charles Gairdner, The Women's & Children's and Fremantle Hospital, introduced devolved management/clinical directorate structures in the 1990s. A simplified schematic of a clinical directorate structure is illustrated below.

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                        ┌─────────────────┐
                        │ Chief Executive │
                        └─────────────────┘
          ┌──────────────────┬─────┴──────────┬──────────────────┐
   ┌──────────────┐   ┌──────────────┐   ┌──────────────┐
   │    Cancer    │   │   Cardiac    │   │ Critical Care│
   │   Services   │   │   Services   │   │   Services   │
   └──────────────┘   └──────────────┘   └──────────────┘
  ┌──────────┬───────────┴──┬──────────────┬──────────────┐
┌──────────┐ ┌──────────┐ ┌──────────┐ ┌──────────┐
│ Surgical │ │Diagnostic│ │Psychiatric││ Medical  │
│ Services │ │ Services │ │ Services │ │ Services │
└──────────┘ └──────────┘ └──────────┘ └──────────┘
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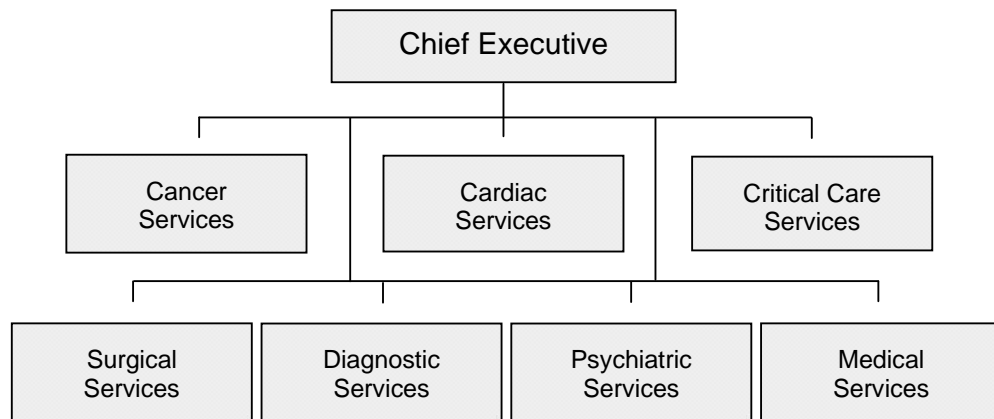
Figure 2.3 A Clinical Directorate Structure

Each directorate usually contains a self-contained clinical service, such as cardiac or cancer services. The size of the directorate and the number of departments held within it will vary from hospital to hospital. For example, a small district hospital may have only 6 clinical directorates whilst a large public teaching hospital may have 12 or more. The number of departments in each directorate can also vary. Too few,

however, and the returns are unlikely to justify the investment in time and effort. Too many and the directorate may become unwieldy (Capewell, 1992).

These units are managed within their own management structure in order to promote:

- Co-ordinated patient care and access through integration of functions.
- Faster identification of changes in the operating environment.
- Greater clinical input into the prioritisation of strategies.
- The speedier adoption of new strategies.
- Improved service planning.
- Improved efficiency of resource utilisation.
- Enhanced clinical access to hospital management at the CEO and Board level.
- Improved communication channels.
- Improved job satisfaction, morale and sense of corporate belonging.
- Improved staff performance.

(Goodier, 1994; Clinical Directorates Implementation Team, 1996)

The emphasis is then on the relationships among healthcare providers within each group, with the benefits seen as being:

- Patient focused groups promoting a team approach to service delivery.
- More effective application of resources through the devolution of decision-making to a level closer to the patient.
- Ability to plan the business.
- Potential for role flexibility.

(Clinical Directorates Implementation Team, 1996)

The essence of restructuring a hospital along such lines is to increase the involvement of all staff in the operational management of their service (Fremantle Hospital, 1995). In other words, clinical directorates offer a mechanism for doctors to be involved in the way in which their clinical service, hospital or unit is run (Capewell, 1992).

Lazarevic (1994:19) reports that despite its advantages, there are some drawbacks to a devolved management structure. They include:

- A reduced ability to pool resources, resulting in a loss of economies of scale.
- A reduced control of organisational-wide policies.
- An increased potential for conflict.
- An ambiguity in dual reporting relationships.

With a devolved management model, much of the management responsibility, authority and accountability held by hospital executives under the traditional structure, is transferred to hospital doctors (Royal Perth Hospital, 1994c). Termed "management from the inside" by Llewellyn (2001:598), the model puts medical rather than non-medical managers into positions that have authority over the decisions made by colleagues. The grand assumption, according to Llewellyn (2001), is that doctors will respond more favourably to management agendas set by medical rather than non-medical managers.

The clinical directorates and the doctors who head them, become the primary 'engines' that drive the hospital, with responsibility for a defined set of clinical services. Within the overall strategic aims of the hospital, they are required to develop the direction and priorities of their specific service (Goodier, 1994; Royal Perth Hospital, 1994c). Carrying the responsibility for total unit management, they are charged with leading and managing change across the professional groups who contribute to their service (Royal Perth Hospital, 1994c).

The structure most commonly found in Western Australian public teaching hospitals is the hierarchical model in which the Clinical Director has either joint or ultimate authority, responsibility and accountability for the directorate. An example of the departmental make-up of clinical directorates is illustrated as follows:
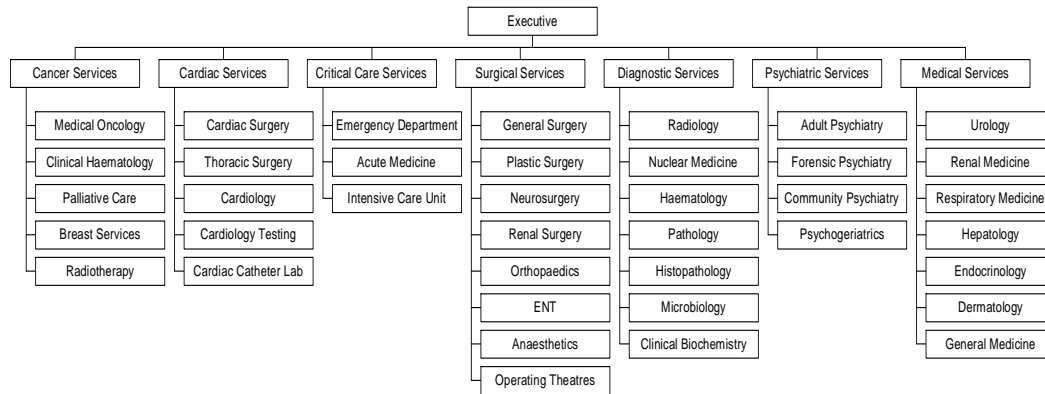
Figure 2.4   Clinical Directorate Management Structure

The organisational structure may vary between institutions; however, the guiding principle in the development of the final structure is the patient's welfare and the provision of the best service possible (Royal Perth Hospital, 1994e).

2.5.1   Responsibilities of a Clinical Directorate

The roles, authority and responsibilities of clinical directorates commonly include:

- Ensuring optimal operational unit management and quality of care.
- End-of-line responsibility for the financial management of the unit.
- Recruiting and managing of all staff.
- Managing material resources including equipment upgrades and purchases.
- Directing process re-engineering initiatives to ensure unit work practices are in accordance with national and international benchmarks and best practices.
- Co-ordinating quality improvement activities and monitoring of service specific clinical indicators.
- Developing service contracts and external funding submissions.
- Developing annual operating plans for the services within the unit consistent with the organisation's business plan.
- Investigating and resolving patient complaints.

(Goodier, 1994)

2.5.2 The Clinical Directorate Management Team

The most common members of a clinical directorate management team are a Clinical Director, a Nurse Manager and a Business Manager (Royal Perth Hospital, 1994d; McGuiness, 1995). In some organisations, a General Medical Practitioner may be included in the management team to provide contact with the local community (Fremantle Hospital, 1995). This group of people are the focal point for the directorate's strategy, policy-making and problem-solving (Sang, 1993).

Depending on the size of the directorate, the Nurse and Business Manager can be either full-time or shared across directorates. Subordinate staff responsible for finance, information technology, medical records and secretarial services commonly support all three of the management team (Capewell, 1992). Many hospitals choose a team approach to the management of their directorates with the lines of authority taking either an hierarchical or co-management form (Capewell, 1992).

2.5.2.1 The Hierarchical Management Model

The hierarchical management model sees the Clinical Director at the apex of the management triumvirate. The Nurse Manager and Business Manager report directly to the Clinical Director and provide critical supporting roles. The Clinical Director has the delegated authority of the Chief Executive and is ultimately responsible for the performance of the directorate.
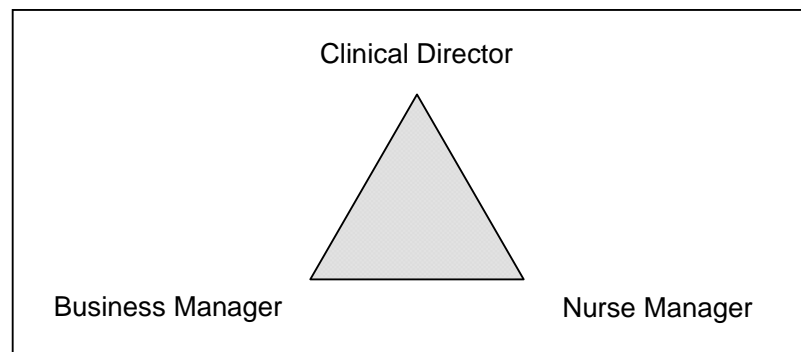
Figure 2.5   Hierarchical Management Model

2.5.2.2   The Co-Director Management Model

The co-director model sees the Clinical Director and Nurse Manager have joint responsibility and authority for managing the directorate. The Co-Directors, have discrete but complimentary job description with some joint areas of responsibility.

Clinical Co-Director   Nursing Co-Director

Business Manager
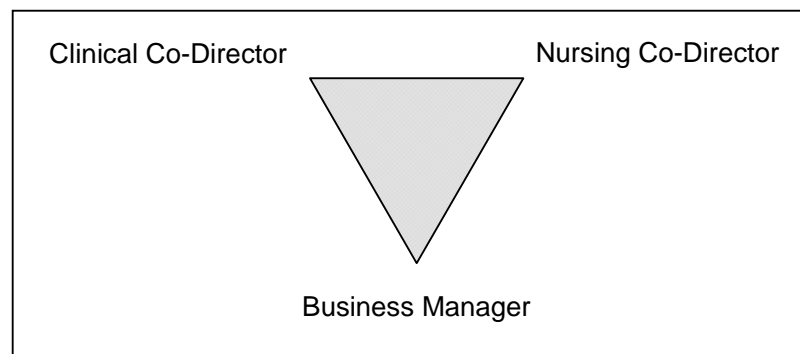
Figure 2.6   Co-Director Management Model

Both of the above structures are common configurations for directorate management teams in Western Australian public teaching hospitals. Of the hospitals that participated in this research, Royal Perth and Fremantle Hospitals have adopted the hierarchical management model, whilst Sir Charles Gairdner Hospital implemented a co-director management model.

2.5.3   Roles of the Directorate Management Team Members

2.5.3.1   Clinical Director

The core responsibility of a Clinical Director according to Sang (1993) is to provide leadership and general management to a specialty or group of specialties. In particular, the Clinical Director takes total responsibility for their directorate's service quality, volume and cost. In practice, however, the role of a Clinical Director is subject to a number of influences such as the size and make-up of the directorate, the degree of control over budget, the time allocated for duties and the level of responsibility for targets and performance (Shortland and Gatrell, 2005).

As would be expected, the Clinical Director is a consultant member of one of the specialties contained within the directorate. They report to the Chief Executive and commonly hold a position on the hospital's executive (Stroobant, 1995). All doctors within the directorate report directly to the Clinical Director. Other members of staff report through their line-manager to the Clinical Director (Sang, 1993).

In most institutions, the Clinical Director can be either a full-time or sessional medical consultant. The amount of time allocated to directorate management varies according to the size, complexity and support provided to the unit. However, a minimum of two and maximum of five sessions (of 3.5 hours) per week is common practice (Goodier, 1994). The length of appointment can vary according to the institution. Stroobant (1995) suggests a period of three years is an adequate return on the training investment and is a sufficient length of time to allow long-term policy to be devised and implemented. Stroobant (1995) believes that it is important to set fixed periods of appointment so that no one remains in the post indefinitely and autocracy is avoided.

Under a directorate structure the Chief Executive devolves executive power, authority and responsibility for all directorate matters to the Clinical Director. An important role for a Clinical Director is to manage and plan how the services of their directorate are to be delivered. From an organisational-wide perspective, they must take into account the priorities of the organisation in their contribution to the strategic planning process. This would include identifying service priorities and developing and aligning a directorate service plan with the hospital's overall strategic objectives. They must be able to establish the means to respond rapidly to change and external pressures (Royal Perth Hospital, 1994d).

The extent of budgetary devolution varies from institution to institution. In a fully devolved model, Clinical Directors will have budget responsibility for both staff and non-staff budgets. Non-staff budgets include responsibilities for internal or external contracts on clinical services such as radiology, pharmacy and pathology and non-clinical support such as laundry and waste disposal. In a less sophisticated directorate model, Clinical Directors may have little or no budgetary responsibility. This will of

course lead to frustration in trying to meet corporate targets on expenditure and quality (Dawson et al, 1995).

Bernstein (1993) believes in the fully-devolved model and that Clinical Directors need to take some responsibility for budget control. Whilst Bernstein (1993) is of the opinion that a Clinical Director should not worry about each line-item in a budget, he believes they must be able to monitor the 'bottom line'. Detailed explanations on spending can be achieved through regular counsel with the directorate's Business Manager. Bernstein (1993) sees the Clinical Director's financial role as helping the Business Manager to correct overspending, create a business plan and negotiate future budgets.

Kitchener (2000) feels that budgetary responsibility is an important trigger to encourage the involvement of Clinical Directors in contract negotiations with suppliers and purchasers. He believes that their participation in negotiations often helps them to develop knowledge of markets and competition and ultimately, a more entrepreneurial approach to their role.

Clinical Directors must be able to monitor information about performance and participate in the audit of clinical practice. As the quality of information systems (and hence accuracy of clinical data) can vary enormously across organisations, it is important that Clinical Directors place a high priority on developing valid clinical databases (Dawson et al, 1995). They can then actively collect, monitor and feedback information that they perceive as being important to good quality practice (Bernstein, 1993).

Part of the quality circle involves feeding back information on clinical practice to their colleagues. Pollard (1994) in Mitka (1994:31) describes how:

> "Professionals in general and physicians in particular, accept advice and counselling better from a peer than from someone in another discipline."

Although peer review systems are very difficult to administer to doctors, Pollard (1994) believes that ideally, a significant proportion of a Clinical Director's time should be devoted to evaluating medical staff performance.

Another key function of a Clinical Director is to unify the staff to work for the common good of the directorate rather than their individual departments (Bernstein, 1993). Affirming the directorate's identity and establishing a common purpose are important requirements according to Sang (1993). One way that this can be achieved, would be to extend the role of department managers, so that they take on responsibilities from a directorate perspective. This allows the directorate management team to concentrate on strategic rather than day-to-day issues. Without such delegation and support, the Clinical Director's finite management time would be constantly burdened with operational issues (Bernstein, 1993).

Clinical Directors must also be able to manage what can be complex relationships with other parts of the hospital. This can take the form of contracting, competing, co-operating or negotiating with other directorates (Sang, 1993; Dawson et al, 1995).

A Clinical Director must also be able to fairly represent their directorate at Executive level. Whilst required to argue their own directorate's causes with intelligence and knowledge, a Clinical Director must also look at the common good of the organisation. In contributing to hospital policy, their decision-making must be sympathetic to other directorate's causes if they consider them to be more pressing (Bernstein, 1993; Royal Perth Hospital, 1994d).

2.5.3.2   Business Manager

For the most part, Business Managers are directly accountable to their Clinical Director. Their roles and responsibilities vary from hospital to hospital. However, they are commonly responsible for the performance of administrative staff within their directorate. Possible roles include information management, human resource management and accounting. Larger directorates may have dedicated staff responsible for these roles (Capewell, 1992). The Business Manager typically

provides budget and accounting advice to the Clinical Director. They work closely with the Nursing Manager to ensure the efficient utilisation of resources.

2.5.3.3 Nurse Manager

Typically, the Nurse Manager has professional and managerial responsibility for the nursing staff within the directorate. The directorate's standard of clinical care, is the Nurse Manager's most important professional responsibility. Their management role can include staff selection, appointment, training and development. Their hardest, but most important task, according to Hancock (1991), is to manage compliance with a level of work that is compatible with available resources. In some hospitals, the Nurse Manager is also responsible for the management of support staff such as orderlies and cleaners (Hancock, 1991).

The Nurse Manager is usually responsible to the Director of Nursing for professional issues and the Clinical Director for management and service issues (Hancock, 1991). They work closely with the Business Manager to ensure that all the needs of the directorate are met. In some clinical directorates, a nurse rather than a doctor is appointed as Clinical Director (Disken et al, 1990; Stroobant, 1995). In other circumstances the role of the Nurse Manager and Business Manager may be combined (Disken et al, 1990; Capewell, 1992).

2.6 Barriers to Clinical Directorate Success

2.6.1 Deficient Clinical and Financial Information

According to Disken et al (1990), the success of organisational change in healthcare is dependent upon the availability of accurate information on clinical activity and costs. The information required not only includes financial data such as budgets, income and expenses, but also performance data such as length of stay and bed usage (Heyssel et al, 1984). Valuable synergies can develop if information systems and organisations develop in tandem. Particularly, if information systems are developed that recognise each functional unit as an independent operation (Heyssel et al, 1984). From a management perspective, Clinical Directors need accurate performance indicators to assess improvements in the quality of patient care (Lazarevic, 1994).

They are only able to make more effective and influential decisions when they receive timely and accurate information. Conversely, the same group may become disempowered, disenchanted and vulnerable if the information they receive is inaccurate or inadequate (Disken et al, 1990; Dopson, 1994).

2.6.2   Lack of Directorate Resourcing

Dopson (1994) discovered that a lack of adequate resourcing for clinical directorates and their directors is a source of disgruntlement for Clinical Directors. Appropriate funding during the implementation stage of structural change is crucial for directorate success (Robbins, 2007). For example, investments in support staff (financial and secretarial) as well as financial and information systems need to be made in order for directorates to operate productively. Robbins (2007) believes that for New Public Management reforms to succeed, those who have been devolved accountability must be provided with the appropriate tools.

Research by Dopson (1994) suggests that from a Clinical Director's perspective, the funding of only 2 half-day sessions per week for management work is insulting. In addition, doctors who take on Clinical Directorships suffer considerable personal and opportunity costs due to the significant amount of time that is invested in performing the duties of a Clinical Director. Kitchener (2000) reported that Clinical Directors in his study spent more than double their contracted hours on management work - most of which was undertaken in their own time. Capewell (1992) believes that to attract the best people to these potentially demanding posts they should be well rewarded financially.

All in all, Robbins (2007) is of the opinion that New Public Management ideas are doomed to fail unless changes in institutional structure are matched by support mechanisms such as time, money, staff and information systems.

2.6.3   Incomplete Delegation of Authority

The authority to make decisions must be accompanied by the transfer of responsibility (Heyssel et al, 1984). Provided decisions are made according to hospital policy, Clinical Directors should be able to control their directorate's destiny.

Lazarevic (1994) believes that a major barrier to devolved management success is the failure of executive management to delegate responsibility and authority to those at the clinical service interface.

Furthermore, Heyssel et al (1984) are of the opinion that the executive management should surrender and redefine their roles when delegating responsibilities to clinical directorates. Rather than focussing on operational issues, their new roles should look at hospital-wide policy development and performance monitoring of the directorates.

2.6.4 Lack of Clinical Director Commitment

Just as Chief Executives must learn to relinquish control, Clinical Directors must commit to accepting the responsibility of managing their directorates. Heyssel et al (1984:1479) comment that:

> "Although physicians frequently think that hospital administrators
> are not responsive to their needs, and decisions are not made in a
> timely manner, they shy away from direct involvement."

It follows that doctors committing time to learning and performing the role of a Clinical Director are important aspects to clinical directorate success.

2.6.5 Resistance by the Nursing Profession

According to Heyssel et al (1984) the decentralisation of nursing services is potentially the most difficult task when developing a devolved management structure. Concerns raised by the nursing profession can include loss of budget control, loss of power and changes to the reporting structure. Although in some cases the nursing profession has expressed a difficulty in being managerially responsible to doctors (Heyssel et al, 1984), issues of professional accountability are aligned through professional responsibility to the Director of Nursing. Loss of power and budget control tend to become non-issues as Nurse Managers of clinical directorates take on significant responsibilities as part of the directorate management team.

2.6.6   Poor Succession Planning

According to Dawson et al (1995), succession is an issue that concerns many Clinical Directors. With too little succession planning, suggests Shortland and Gatrell (2005), it can take up to 1 or 2 years before a Clinical Director can fully contribute to the management of a directorate (Shortland and Gatrell, 2005).

Without appropriate succession planning, it is quite possible that wrong person for the wrong reasons will fill the position. Mitka (1994) describes how in the past it has been a common practice to select older doctors to fill the role of manager. With reference to Pollard (1994), Mitka (1994:30) writes:

> "These days it is no longer appropriate to fill these roles with semiretired physicians….physicians gliding into retirement are rarely prepared to take on the demands on a new career effectively."

Dawson (1995) believes that few doctors are willing to take on the difficult role of management and often those in Clinical Director positions, have been coerced or found themselves the only people nominated. When this sort of thing happens, it follows that their colleagues will show little motivation to be the next in line. Some feel trapped according to Dawson et al (1995) in a job that they believe should be rotated among their colleagues. Without succession, suggests Dawson (1995), those in Clinical Director positions will most likely become institutionalised; lose their desire to achieve and a freshness of approach.

2.6.7   No Incentives

One of the major incentives for doctors to be involved in devolved management is to share in the benefits of improved performance. This may take the form of retaining any end of year budget savings. To this end, Executive expectations must be very specific with regard to agreed budgets, levels of expected activity, cost projections and performance targets. Lazarevic (1994) believes that not being specific in these areas can lead to the failure of a devolved management structure. Disagreements between the executive management and clinical directorates on clinical management can potentially challenge the integrity of the structure (Lazarevic, 1994).

2.6.8 Lingering Bureaucratic Practices

Robbins (2007) describes that the prevalence of lingering bureaucratic practices has been an obstacle to the successful implementation of New Public Management concepts in hospitals. The perpetuation of parallel hierarchies and the constraint of traditional business practices have, according to Robbins (2007), impeded the change process in hospitals. According to Robbins (2007), the removal of these impediments would result in a more proactive form of management. Controls would be removed, accountability would be devolved and information would be shared more readily.

2.7 The Clinical Mentality

Because of the nature, complexity and importance of the work doctors perform in hospitals, they are often given considerable autonomy over the work they do and how they perform their duties (Pointer and Sanchez, 1994). This, combined with the long and intensive education and socialisation process doctors undergo, contributes to the cognitive framework or mentality by which they operate.

Kaissi (2005:168) believes that doctors and managers possess two different modalities of thinking. Managers are instrumental in their thinking, their mindset is:

"We do what we do to pursue goals, to compete, or to maximise profits."

Doctors, on the other hand suggests Kaissi (2005:168), do not need a rational explanation, they think:

"We do what we do because it's the right thing to do."

Doctors, according to Willcocks (1994b), clearly perceive management differently to that of managers. They hold a different set of understandings, beliefs and expectations as to what management entails. Petasnick (2007) describes how, often using their private practice model as a basis for understanding, doctors tend to think in terms of practicing their specialty well, seeing more patients or increasing revenue. Hospital executives on the other hand, think in the wider terms of managing the

hospital as a whole. They look at balancing the demands of specialties (and doctors), budgets, strategies and the overall service delivery of the hospital.

Aside from differing perceptions, Willcocks (1994b) points out that doctors also have difficulty in relating to managerial concepts such as vision, or understanding managerial language. In the same way that medical terminology is foreign to managerial staff, Willcocks (1994b:30) discovered that many doctors found managerial language to be "incomprehensible jargon".

Pointer and Sanchez (1994) and Dye (1996) suggest that there are a number of critical aspects of this 'clinical mentality' that contrast with that of managers. Dopson (1994:27) describes the contrast as being different "thought styles" derived from different "thought collectives".

Aspect	Clinical Mentality	Managerial Mentality
Primary Allegiance	Client	Organisation
Responsibility	Personal	Shared
Authority Relationships	Collegial (Horizontal)	Hierarchical (Vertical)
Time-frame	Short/Present	Long/Future
Feedback	Immediate & Concrete	Delayed & Vague
Ambiguity & Uncertainty Tolerance	Low	High
Decision-making process	Heuristic	Analytical
Management Style	Authoritarian	Participative
Causal Perspective	Blame	Systems
Problem-solving	Empirical	Intuitive
Promotional Aspiration	Advancement	Achievement

Table 2.1   Comparison of Clinical and Managerial Paradigms
Source: Pointer and Sanchez in Shortell and Kaluzny (1994); Dye (1996);
Zaher (1996); Kaissi (2005)

As illustrated in the preceding table, the cognitive frameworks of doctors and managers are quite different. Shipman (2007) supports the concept of different management and doctor paradigms. He cites a series of differences including:

- Managers care about a hospital's mission whilst doctors care about their patients.
- Managers are educated, experienced and grounded in business, whilst most doctors care little or know little about the rules of business.
- Managers are mostly proactive, whilst doctors tend to be reactive.
- Mangers tend to be risk-takers whilst doctors are risk-averse.
- Managers see bigger as better whilst doctors focus on one patient at a time.
- Managers are accustomed to working with groups whilst doctors are trained to work with individual patients.
- Managers earn their keep by managing the productivity of others, whilst doctors get paid according to their own productivity.

Pointer and Sanchez (1994) suggest that the differing cognitive paradigms explain why doctors often misinterpret the behaviour of managers. One must question, therefore, whether doctors who undertake managerial roles such as clinical directorships, manage with a 'managerial' mentality? If they do, their management behaviour may be perceived and interpreted by other doctors as being different to what was intended. Their ability to motivate fellow clinicians may not be as effective as it was prior to taking on a managerial role or, they may become prone to negatively misinterpreting the intentions or behaviours of their colleagues (Pointer and Sanchez, 1994).

Interestingly, research by Llewellyn (2001) found that Clinical Directors tend to depict their management tasks as marginal to their overall responsibilities. She believes that this sort of thinking poses problems for the Clinical Director in their attempt to rationalise their role and suggests that this may explain why Clinical Directors tend to adopt a more managerial mindset, but never describe themselves as primarily managers.

It would seem that in order for devolved management structures in hospitals to succeed, Clinical Directors must be able to consistently wear both caps. That is, to be

able to concurrently think in both 'managerial' and 'clinical' paradigms. Unfortunately, this important proposition appears to have been largely ignored by many hospitals that have progressed to devolved management structures. The complexity of the struggle between the 'managerial' and 'clinical' paradigms is largely ignored. Senior management often assume that if a clinician is a good clinician, then they must be a good manager.

2.8 Motivations for Doctors to Move into Management

The literature suggests that the motivation for doctors to move into management is based on a variety of interacting factors.

Research by Fitzgerald (1994) found that there were numerous motivations for doctors to assume management roles. The primary ones, however, were power and influence. Clinical directorships guarantee doctors access to senior management discussions. The new and more powerful roles that they assume allows them to not only participate in the management process, but also enables them to influence the way in which healthcare is managed. Many doctors find dealing with the big picture, planning for the future and having organisational-wide influence to be a rewarding opportunity (Simpson, 1994).

The changing structure of management roles within healthcare has also been a significant motivation. Prior to the introduction of devolved management structures, the only opportunity for doctors to be involved in management was through full-time medical administrator positions. This proved a disincentive to doctors, as the move tended to be irrevocable, their clinical role disappeared and their earning capacity was diminished. The advent of devolved management has seen the creation of part-time management positions that allow doctors to participate in management whilst still maintaining their clinical role (Fitzgerald, 1994).

Doctors are also attracted by the allure of a new challenge according to research by Fitzgerald (1994). The stimulation and interest that is generated by entering a new profession was considered by many of Fitzgerald's cohort to be a powerful motivator. Similarly, Simpson (1994) suggests that solving management problems appeals to

their creative talents of doctors and that such involvement is both a refreshing and stimulating challenge. Being caught in a static medical career structure can also be a motivating factor. After reaching consultant status, a doctor often faces 20 to 30 years without further career movement. Fitzgerald (1994) found that the opportunity to embark on a new career in management after reaching the medical career ceiling is a challenge many doctors embrace.

2.9   The Challenges of Moving from a Doctor to a Manager

Working in a clinical directorate environment presents a number of challenges for the doctor who moves into a management role. From an operational perspective, they can experience issues associated with understanding the management perspective, their educational background and lack of management training. From a personal perspective, they face underlying cognitive and ethical issues.

2.9.1   Understanding the Management Perspective

The world of management can present a new and often unfamiliar environment to clinicians. Brown and Mayer (1996:35) suggests that:

> "The integration of physicians into a corporate environment is akin to blending two distinct cultures during a merger."

Although doctors are considered to be among the best-educated members of staff in a hospital, the skills required for effective management are different to their clinical skills (Buchanan et al, 1997; Leggat et al, 2006). The challenge they face is to adapt the problem-solving skills they utilise for the individual patient to organisational-wide issues.

Unlike the clinical environment, Clinical Directors are often faced with the loss of their expert authority when it comes to management issues. Often untrained in management, Clinical Directors can find it difficult to cope with challenges to their authority and must therefore learn a new political context when dealing with management issues (Leggat et al, 2006). Just as unsettling is dealing with

management tasks that are "ad hoc, ambiguous and fragmented" (Leggat et al, 2006:31). To the inexperienced Clinical Director, this environment can prove to be quite alien.

2.9.2   Insufficient Management Training

Bailey (1995) suggests that doctors are in general, poorly integrated into the management structures of their hospitals. The major obstacle he proposes is their background and training. Zaher (1996) agrees. She believes that many of the management skills required in today's health environment do not come naturally to doctors. Bailey (1995) is of the opinion that, with no formal management training, doctors mostly rely on unwritten rules and learning by doing.

Lack of management training and preparation for the role of clinical directorship has proven to be a common theme over time (Buchanan, 1992; Willcocks, 1994a; Corbridge, 1995). Although short courses and training days in management are occasionally offered, Buchanan (1992) found that Clinical Directors are of the opinion that they lack sufficient management training to effectively perform their role. Capewell (1992) proposes that Clinical Directors should have formal management training in areas such as budgeting and information management.

2.9.3   Cognitive Issues

Zaher (1996) describes a variety of cognitive factors that impact upon the move from clinician to manager. They include:

- Psychological adjustment.
- A change from independent to dependent role.
- A change in focus from patient to organisation.
- A naivety about organisational dynamics.
- New skill requirements.
- A change in role from controlling to persuasion.
- A change from a collegial relationship to one based on authority.
- A change in focus from medical to business competence.

In addition, many Clinical Directors fear that the role of manager erodes their clinical autonomy and presents a conflict between the needs of the organisation and the needs of their individual patients (Kennedy, 1990; Stuart et al, 1995; Elina et al, 2006). Their philosophy of putting patients first can at times conflict with a Director's budgetary and managerial responsibilities (Capewell, 1992). Willcocks (1995:19) agrees:

> "The attempt to introduce managerial responsibility and accountability and at the same time retain considerable professional autonomy has brought with it certain tensions."

Boyce (1994) proposes that the clash of professional and managerial cultures and the tension it generates is a limiting factor to the effectiveness of Clinical Directors. Braithwaite and Westbrook (2005) support this thought. They suggest that those appointed to Clinical Director positions may experience ethical dilemmas or compromising of their clinical values.

2.9.4   Ethical Issues

The effectiveness of a Clinical Director partly relies on their ability to recognise and deal with the ethical issues associated with resource allocation (Lemieux-Charles et al, 1993).

Research by Lemieux-Charles et al (1993:272) identified three categories of ethical issues faced by Clinical Directors in devolved management structures. The issues are grouped according to organisational level (micro-, meso- and macro-) and are summarised in the following table:

1. **Micro-level issues**
    - Moral obligation to provide high quality care
    - Conflict between providing high quality care and cost-effective efforts
    - Conflict of interest (doctor payment incentives and institutional objectives)
    - Clinician/managers' intra-personal conflicts (professional responsibilities -v- management responsibilities

2. **Meso-level issues**
    - Determining priorities for care
    - Inter-professional conflicts (conflicts with individual professional's standards of practice and cost-containment efforts)
    - Intra-professional conflicts (Clinical Director -v- colleagues)
    - Patient selection criteria and their influence on access to care
    - Relationship of directorate activities to the hospital's mission
    - Equitable allocation of resources across the hospital

3. **Macro-level issues**
    - Needs of the community -v- the needs of the hospital

Table 2.2   Ethical Issues Faced by the Clinical Director

Adapted from Lemieux-Charles et al (1993:272)

The micro-level issues are mostly associated with a doctor's perception that their increased involvement in resource allocation (both human and financial) could jeopardise their patient's quality of care (Zaher, 1996). The dilemmas they face range from deliberately exceeding budget by consciously overusing resources, to manipulating data so that it would support the type of patient care they deem appropriate (Lemieux-Charles et al, 1993).

Meso-level issues mainly relate to the interface between the directorate and the hospital. They primarily consist of issues surrounding a doctor's conflict between managerial and clinical responsibilities, anxieties associated with determining priorities for care and conflicts between the hospital's strategic goals and individual patient care (Lemieux-Charles et al, 1993).

Macro-level issues consist mostly of the dilemmas that doctors face in balancing hospital policy with the community's expectations of levels of care. Being placed in

a "gatekeeper" role can compromise a doctor's relationship with their patients (Lemieux-Charles et al, 1993:272).

Lemieux-Charles and Hall (1997) point out that the conflicts that arise from having to deal with these ethical issues can create dissatisfaction among Clinical Directors and hence affect their ability to make optimal decisions.

2.10 Chapter Summary

This chapter has introduced the concept of New Public Management - a management philosophy that governments, worldwide, have used since the early 1980s to reform and modernise their public sectors.

New Public Management is based on the premise that efficiency and effectiveness will result from the introduction of private sector practices into the public sector. In effect, it has seen managers in the public sector be allowed to manage. Less bureaucratic environments have made public sector managers more accountable for their expenditure and allowed them to improve organisational performance through private sector concepts such as benchmarking, comparability, contestability, choice and competition.

Public healthcare in particular, has seen significant structural and management changes introduced as a consequence of New Public Management reforms. The devolution of management and the introduction of management techniques such as Managerialism have seen doctors become more empowered and more involved in the management of healthcare.

Being the greatest consumers of healthcare resources and the primary decision-makers in how resources should be utilised, doctors are the ideal candidates to determine how the healthcare dollar should be spent. In public teaching hospitals, the method that has been used to encourage doctors to manage healthcare expenditure has been through structural change and the creation of devolved management units called clinical directorates.

Whilst various clinical directorate models exist, those that have been established in the Western Australian context are structured according to service (eg cardiac services, cancer services and so on). In the case of Royal Perth and Fremantle Hospitals a Clinical Director heads them. In the case of Sir Charles Gairdner Hospital, they are co-managed by a Clinical Director and Nurse Manager.

The devolution of management to doctors can produce many benefits such as improved patient care, better utilisation of resources and a greater clinical input into strategies to name a few. However, for those doctors who head the clinical directorates, the concept of management can be quite foreign. It has been suggested that doctors think according to a completely different paradigm to that which professional managers use. This 'clinical mentality' can produce various perceptive, cognitive and ethical challenges to those doctors who take on management roles.

With so many challenges to overcome, the question of what makes a Clinical Director efficient and effective becomes all the more intriguing. The following chapter describes the process by which this question was researched.

Chapter 3 Research Methodology

3.1 Introduction

This chapter presents the methodological issues related to this study. The research design and methods used in the study are outlined. The development of the interview process, data collection and data analysis are also discussed.

The methodological issues discussed in this chapter include assumptions underlying qualitative research, methodological considerations and the grounded research approach.

The chapter is organised such that the theoretical perspectives that informed and guided the research are first discussed. A summary of the problem, the objectives of the study, the research question and significance of the study then follow. Aspects of the research design, data collection and analysis complete the discussion.

3.2 Determining a Method of Inquiry

Choosing between a quantitative and a qualitative approach to any study is largely determined by the research question itself (Strauss and Corbin, 1998; Morse and Richards, 2002). Both the nature and the type of research problem had important bearings on what approach would ultimately be adopted (Holloway, 1997). For example, qualitative questions according to Creswell (1998) often start with a 'how' or 'what'. They look to investigate a topic and describe its meaning.

The purpose of this research was to determine the dimensions of efficiency and effectiveness of Clinical Directors in Western Australia's public hospital system. To this end it initially satisfied the rationale for choosing a qualitative approach. The research question for this study commences with a 'what'. It asks what are the dimensions of efficiency and effectiveness?

The purpose of the study, suggests Creswell (1998), is also an important factor in determining if a qualitative approach is appropriate. Creswell (1998) believes that

qualitative approaches are most suited to topics that need to be explored, where variables are not easy to identify and where theories are yet to be developed. Holloway and Wheeler (1996:2) agree:

> "Qualitative research is especially useful where little is known about the area of study and the particular problem, setting or situation, because the research can reveal processes that go beyond surface appearance. It provides fresh and new perspectives on known areas and ideas."

In support of the above discussion, the purpose of this study lent itself to a qualitative approach. Although a number of studies have been performed on related topics in the United Kingdom and the United States, the researcher found no prior theory to guide research on the dimensions of efficiency and effectiveness in the clinical directorate setting. The dimensions of efficiency and effectiveness would need to be discovered, fully investigated and then used to develop a framework from which they could be explained and explored in the setting of Western Australian public teaching hospitals.

Creswell (1998) also suggests that the research question must lend itself to presenting a detailed view of the topic from the perspective of the participants in their natural setting. It must encourage the researcher to be an active participant in the process (Creswell, 1998). On these grounds, a qualitative approach designed to explore the dimensions of efficiency and effectiveness appears to again be supported. Through the researcher gaining access to Clinical Directors and their colleagues in the hospital setting, a meaningful and contextual exploration of the topic would be achieved.

Bearing the above-mentioned rationale in mind, it was important that the commitment to immersing oneself in the process was not underestimated. The qualitative approach to data collection, analysis and review can be a time consuming and sometimes exhausting process. Field interviews, transcription and analysis would require the researcher to become an active learner rather than an expert passing judgement on participants (Creswell, 1998). Being employed within the health field, it was important for the researcher not to introduce preconceptions or biases into the conversations or analyses. Rather than project opinions and ideas, all that was simply

needed was to "tell the story" from the participants' point of view (Creswell, 1998:18).

Whilst the research question and the preceding principles led this research towards a qualitative approach, it was important that the underlying methodological assumptions and epistemological stance also supported the choice of a qualitative approach.

3.3   Working Qualitatively

To work qualitatively is to look at the way people interpret and make sense of their experiences and the world in which they live (Holloway, 1997). It helps researchers, to make sense of the world in a particular way with the aim of understanding the social reality of those who are studied (Holloway, 1997; Morse and Richards, 2002).

The literature offers a variety of definitions of qualitative research. They range from an emphasis on the practical through to those that focus upon the interrelationship between researcher, participant and the setting for inquiry. For example, Leininger (1986:5) narrowly defines qualitative research in terms of methods and techniques.

> "The qualitative type of research refers to the methods and techniques
> of observing, documenting, analysing and interpreting attributes,
> patterns, characteristics and meanings of specific, contextual or
> gestaltic features of phenomena under study."

In contrast, Denzin and Lincoln (1994:2) offer a more comprehensive definition by further describing qualitative research in terms philosophy, approach and setting. They write:

> "Qualitative research is multi-method in focus, involving an
> interpretive naturalistic approach to its subject matter. This means
> that qualitative researchers study things in their natural setting,
> attempting to make sense of or interpret phenomena in terms of the
> meaning people bring to them. Qualitative research involves the
> studied use and collection of a variety of empirical materials – case

study, personal experience, introspective, life story, interview, observational, historical, interactional and visual texts – that describe routine and problematic moments and meaning in individual lives."

As suggested by this definition, qualitative research is grounded by a set of assumptions that underlie the research design. It is important one recognises that such assumptions can influence the research in many ways. For example, they could influence the researcher's perspective, the purpose of the research or how the research question is addressed. Ultimately, they determined how the research will be approached, what methods will be used and the strategy of inquiry that will be adopted (Holloway, 1997).

Creswell (1998) outlines five philosophical assumptions that guide the process of qualitative inquiry and are central to conducting good qualitative research. They are:

- Reality is subjective and multiple

- The researcher has a collaborative relationship with the participants

- The researcher's and participants' interpretations are shaped by their values, as is the narrative

- The language of the research is literary, informal and uses qualitative terms

- The research process uses an emerging design, inductive knowledge and is contextual

McCabe (2002) synthesises a view of the underlying assumptions of qualitative research from a more practical perspective and categorises them from the perspectives of the researcher and the research.
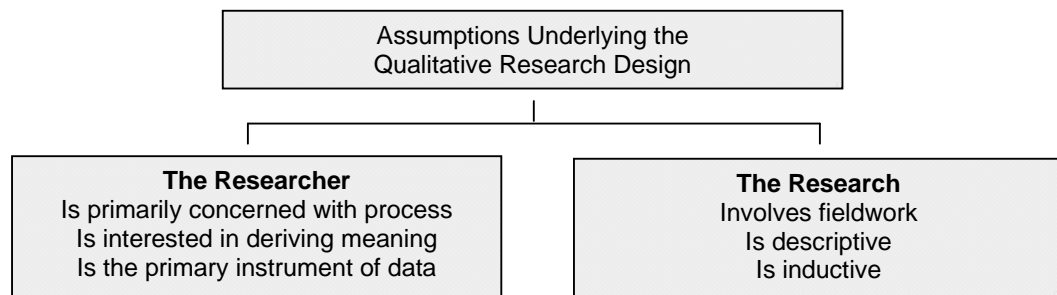
Figure 3.1   Assumptions Underlying Qualitative Research Design
Source: McCabe (2002:32)

As illustrated in Figure 3.1, the qualitative researcher is primarily concerned with process, is interested in deriving meaning from the study's participants and is the primary instrument of the data.

Being primarily concerned with process means that rather than viewing the research as a product (Creswell, 1998), a researcher must look at the research in its entirety. They need to accept and appreciate the research as an evolving process that has many valuable and interesting facets. That is not to say that the research design would be without structure. Being primarily concerned with process also means that the researcher will need to follow a series of specific steps that hold true to the chosen method of enquiry (Cormack, 1996).

The intention to derive 'meaning' from those who participate in this study was a key assumption that inspired this research. People give meaning to their actions and interactions with others (Holloway, 1997). To them, those experiences make perfect sense. To successfully answer the research question, the researcher is required to critically interpret and coalesce their thoughts. Searching for meaning by trying to understand the interpretations and motivations of the many respondents proved to be a challenging and enlightening experience.

A qualitative approach to this research also meant that the researcher became the primary channel through which the data flowed. Holloway and Wheeler (1996) describe how in qualitative research, the researcher is generally considered to be the main research tool.

> "Observation and interview show how participants affect the social
> world and what factors and conditions influence them. Researchers
> therefore have to become immersed in the setting and the situation of
> the informants and describe them in lively detail."

(Holloway and Wheeler, 1996:16)

As illustrated in Figure 3.1, the assumptions that underlie the qualitative research design also drive the research itself. It shows that qualitative research tends to involve a large amount of fieldwork, is generally descriptive in nature and inductive rather than presumptive of theory.

In proposing a qualitative approach one must accept that a large amount of fieldwork will be necessary. This commonly involves visiting the study's participants in a setting that is familiar to them. To this end, a conscious decision was made to interview all of the study's participants at their place of work. In all cases, the interview process was conducted in the participant's office. This strategy helped with immersion in the setting of the research. As suggested by Holloway (1997), it is important to become familiar with the participants' world in order to understand their perceptions. By interviewing participants in surroundings that were comfortable to them, it was hoped to become part of the research setting and to know it intimately. However, having a health industry background, it was important to take the advice of Holloway (1997) and be careful not to become over-familiar with the setting and miss significant issues or considerations. As Holloway (1997:7) suggests:

> "To be able to examine the world of the participant, researchers must not take [the participant's] world for granted but should question their own assumptions and act like strangers to the setting. As naïve observers, they make the familiar strange."

An underlying assumption of the qualitative research design is that it is essentially descriptive in nature. Qualitative research concentrates on words rather than numbers explains Porter (1996). It looks to describe peoples' interpretation of facts rather than seek to identify facts or explain them. In the case of this study, it involved the systematic collection of data about the phenomena being investigated (the efficiency and effectiveness of Clinical Directors) and then the transformation of that data from "text to theory" (Flick, 2002:12). The description of the phenomena was not simply a neutral recording of the data, but rather an essential step in the construction of reality (Flick, 2002).

An assumption that distinguishes qualitative from quantitative research is that it is an inductive process. It seeks to develop theory from data that has been obtained from a natural setting (Porter, 1996). A search of the literature failed to reveal a theoretical framework that could test the dimensions Clinical Directors' efficiency and effectiveness. The need to generate an inductive theory therefore became apparent.

Reflection upon the abovementioned assumptions clearly suggested that a qualitative approach to enquiry was required for this study. However, before developing a research design, the theoretical philosophies that underpin qualitative research needed to be considered.

3.4   The Theoretical Foundations of Qualitative Research

Qualitative research is founded upon a number of theoretical assumptions that are classified according to levels of understanding (Porter, 1996). It was acknowledged that these fundamental theoretical aspects would determine how this inquiry would proceed. They were the researcher's ontological and epistemological perspectives. In other words, how the researcher viewed reality and the nature of knowledge.

3.4.1   How Reality is Viewed (Ontology)

Qualitative research is much influenced by a branch of philosophy known a phenomenology. Porter (1996:115) states that the basic premise of phenomenology is that:

> … the nature of the outside world can never be fully known. All that
> can be known are people's perceptions and interpretations of that
> world."

As the preceding definition suggests, phenomenology is not just about describing phenomena. It looks at the meaning of people's experiences in regards to a phenomena (descriptive phenomenology) and how those experiences are interpreted (hermeneutics) (Polit and Tatano Beck, 2004). In the case of this study, the

phenomena to be described and interpreted are the efficiency and effectiveness of Clinical Directors.

In focussing on perceptions and interpretations, phenomenology suspends judgement on the question of whether reality exists in order to focus on describing and/or interpreting the experience of human existence. As a consequence, reality is not fixed, it can change and develop according to people's experiences and the social context in which they find themselves (Porter, 1996). Porter (1996) believes that the social context people find themselves in is crucial in determining how they develop their perception of reality. Social context is formed by the day-to-day social interaction people have with their family, friends and co-workers (to name a few). These interactions form their understanding and preconceptions about reality and create what is considered to be the subject matter of qualitative research - social reality (Porter, 1996).

With this study, it is accepted that the participants have developed their own understanding of reality through their life experiences and social interaction. Their social reality of the phenomena under investigation (the efficiency and effectiveness of clinical directorship) will in part be guided by their role experiences and workplace interactions.

The ontology for this research is therefore one that acknowledges multiple realities. Known as a relativist ontology, it is defined by Guba and Lincoln (1994:10) as one in which:

> "… realities are apprehendable in the form of multiple, intangible mental constructions, societally and experientially based, local and specific in nature and dependent for their form and content on the individual persons or groups holding the construction."

The multiple realities would come from the many data sources that will be contributing to this research. They include Chief Executives, Clinical Directors, Nurse Managers, Business Managers and Heads of Departments. Each respondent

within these groups will view the reality of the efficiency and effectiveness of Clinical Directors differently.

As the reality has been socially constructed within the natural setting of a public teaching hospital, they will not be held to be right or wrong in any absolute sense (Guba and Lincoln, 1994). They will simply create an understanding between the respondents and the researcher.

3.4.2   How Knowledge is Obtained and Validated (Epistemology)

Epistemology is the theory of knowledge (Holloway, 1997). It deals with questions on how we can know about what exists (Porter, 1996). It asks, what is the relationship between the inquirer and the known? (Denzin and Lincoln, 2000).

The relationship between ontology and epistemology is well described by Porter (1996:116):

> "If social reality consists of the experiences and understandings of people, then knowledge of reality will be knowledge of those experiences and understanding."

For this study, the reality of efficient and effective clinical directorship was in the Chief Executives', Clinical Directors', Nurse Managers', Business Managers' and Heads' of Department own constructions of their 'clinical directorate' world. It follows that in order to understand their world, the researcher would need to gain knowledge of their experiences and understand their motives.

Gaining such knowledge, suggests Porter (1996), is not as simple as one may expect. The ability to get inside the respondent's minds in order to fully understand their experiences is debatable. Porter (1996) suggests that the knowledge obtained from respondents is often coloured by the researcher's own experiences.

Establishing an epistemological stance was important in helping to decide the sort of statements that would justify what the researcher believes to exist (Holloway and Wheeler, 1996). It is the researcher's belief that absolute knowledge of reality is simply not possible. Distortion will occur, as the knowledge of social reality will always be coloured by the researcher's interpretations of the respondent's knowledge.

To this end, it followed that the epistemology for this study was interpretive and subjective. Such an epistemology holds that:

> "… the investigator and the object of investigation are assumed to be interactively linked so that the findings are literally created as the investigation proceeds."

> (Guba & Lincoln, 1994:111)

Subjectivity in this context relates to the subjectivity of the researcher. Though cautious not to introduce opinions and prejudices, one must accept that immersion in the setting and relationships with the respondents will affect the study. In addition, the researcher's personality and experiences will also impact upon what is heard, felt and seen (Holloway, 1997).

Despite its negative connotation, subjectivity of the researcher can be considered a resource. As Holloway (1997:149) points out:

> "The investigators' own subjectivity becomes an analytic tool and is built into the research; they do not try to remove it. Using the self as a tool can help the researcher emphasise and build relationships with the informants."

Holloway (1997) describes how the subjective experience should be considered a basis for knowledge. However, to achieve this, one must bracket the root of one's subjectivity (Polit and Tatano Beck, 2004). Rather than concealing assumptions and preconceptions, the researcher must be prepared explore them and consciously set

them aside. Acknowledgement of the researcher's experiences in the teaching hospital setting from both a clinical and managerial perspective therefore becomes mandatory. From a clinical viewpoint, the researcher has experienced dealing with Clinical Directors from a subordinate position. From a managerial perspective, the researcher has performed the role of a Business Manager and has been a part of clinical directorate management team. Working in both roles has undoubtedly resulted in opinions being formed on what the researcher would believe makes an efficient and effective Clinical Director. Holloway (1997) suggests that provided a researcher is self-critical and explicit about any assumptions and preconceptions, the subjectivity that they bring to the study should not be a limiting factor.

3.5   The Research Paradigm

Crabtree and Miller (1992:8) describe a paradigm as representing…

> "… a patterned set of assumptions concerning reality (ontology), knowledge of that reality (epistemology) and the particular ways of knowing about that reality (methodology)."

The interpretive paradigm centres on subjective reality and the interpretation and creation of meaning by human beings (Holloway and Wheeler, 1996). This paradigm sees the social world as a creation of the interactions between individuals rather than one of fixed structure. In the case of respondents to this study, it is acknowledged that no single objective reality exists, just different versions of events (Burton and Bartlett, 2005).

The constructivist paradigm is one of a number of interpretive paradigms (Denzin and Lincoln, 2000). It deals with both the human constructions being studied and the constructions being created by the researcher (Crabtree and Miller, 1992).

As the issues surrounding efficiency and effectiveness in the clinical directorship setting are open to varying perceptions by a variety of people, this study is set within the constructivist paradigm.

This study is set in the 'natural world' of clinical directorates and fits well with the ontological and epistemological stances previously discussed. As described by Denzin and Lincoln (2000:21), the constructivist paradigm …

> "… assumes a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and respondent co-create understandings), and a naturalistic (in the natural world) set of methodological procedures."

Crabtree and Miller (1992:10) use the concept of an interpretive circle to describe the process of constructivist inquiry. They propose that no ultimate truth exists and that context-bound constructions are all part of a larger "universe of stories". When entering the interpretive circle the inquirer must always be rooted to the context. They must be both apart and part of the inquiry.
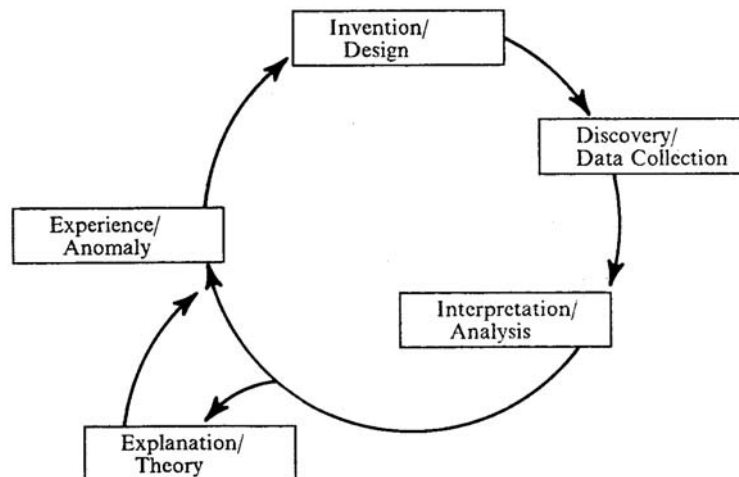
Figure 3.2   Circle of Constructivist Inquiry
Source: Crabtree and Miller (1992:10)

Within this paradigm, reality is seen as dynamic and derived from human interactions that occur in real social and historical settings (Woods and Catanzaro, 1988). It embraces the notion that an observer constructs meaning and that the derived meaning is context dependent (Maione, 1997).

3.6 Using Grounded Theory Principles

This research uses grounded theory principles as a starting point for its methodology. Grounded theory is an approach to data collection and data analysis that aims to develop theory from data collected. Having its origins in symbolic interactionism (Holloway, 1997), grounded theory takes the perspective that reality is negotiated between people, is always changing and constantly evolving (Morse and Richards, 2002).

In contrast with 'grand theory', which uses hypotheses and deduction to test theory, grounded theory uses observation to discover and generate theories that are as close as possible to the reality observed (Rodon and Pastor, 2007).

The grounded theory approach offers a systematic way to shape and handle qualitative data (Charmaz, 2004). Taylor and Bogdan (1998) suggest the process can be illustrated as follows:

```
                    ┌─────────────────────────────┐
                    │        Collect Data          │
                    └─────────────────────────────┘
                                  │
                                  ▼
                    ┌─────────────────────────────┐
                    │    Identify themes or develop │
                    │  concepts and ideas based on data │
                    └─────────────────────────────┘
                          │               │
                          ▼               ▼
    ┌──────────────────────────┐   ┌──────────────────────────────┐
    │ Review and compare other data │   │      Collect additional data    │
    │ ("how do other data relate │   │ ("What additional data might shed │
    │      to this theme?)       │   │      light on this theme")      │
    └──────────────────────────┘   └──────────────────────────────┘
                          │               │
                          ▼               ▼
              ┌────────────────────────────────┐
              │ Confirm/discard/refine/elaborate on │
              │        theme, concept or idea       │
              │    (build theory that fits the data) │
              └────────────────────────────────┘
```
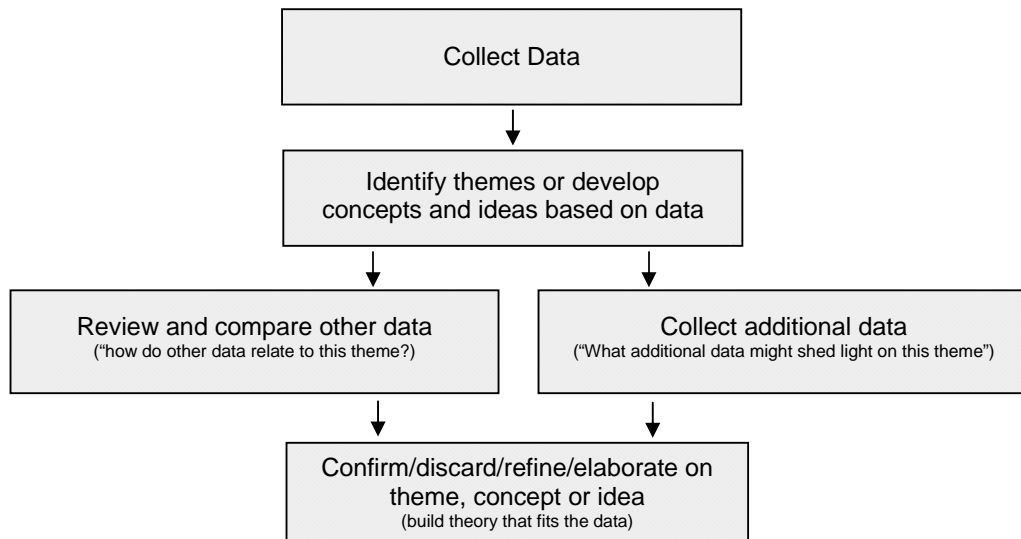
Figure 3.3   The Grounded Theory Approach
Adapted from Taylor and Bogdan (1998:138)

One of the fundamental features of the grounded theory approach is that data collection, organisation, analysis and sampling occur at the same time (Polit and Tatano Beck, 2004; Benton 1996). This process continues until a theory has been

developed that has enough detail and abstraction to explain any variation in the observed data (Benton, 1996).

In developing their approach, Glaser and Strauss proposed two major strategies for developing grounded theory. They are constant comparison and theoretical sampling (Taylor and Bogdan, 1998). Constant comparison involves the simultaneous coding and analysing of data in order to develop concepts (Taylor and Bogdan, 1998), whilst theoretical sampling involves deliberately seeking out study participants based upon their ability to contribute to the topic under study (Morse and Richards, 2002; Holloway, 1997). Both these concepts and their application to this study's data will be discussed in greater detail later in the chapter.

Whilst Glasser and Strauss largely agreed upon key elements of grounded theory such as constant comparison and theoretical sampling, the two founders of grounded theory developed opposing views as to how theory should emerge from the grounded data (Rodon and Pastor, 2007). Whilst Strauss concentrated on developing analytical coding techniques that actively involved the researcher in theory development, Glasser argued that the researcher should be free of preconceptions, take a passive role in theory development and trust that theory will emerge from the data (Rodon and Pastor, 2007).

Debate regarding the legitimacy of grounded theory has circulated for decades. Grbich (1999:179) for example, lists a series of criticisms found in the literature. Briefly, they include:

- The nature of grounded theory has never been properly clarified.
- The link between theory and data has never been properly explained.
- The researcher is centred in a quasi-objective manner.
- It is not possible to ignore existing research and theoretical positions prior to the emergence of categories from the researcher's own data.
- There is an overemphasis on linking to previously discovered theories.
- The process is more suited to concept generation rather than hypotheses testing.
- Refinements to the grounded theory process have resulted in a focus on method and prior knowledge rather than data.

- The relations between basic concepts such as categories, properties and dimensions are poorly defined.
- Other researchers rarely test the theories generated by grounded theory.
- Grounded theory departs from the assumptions of symbolic interactionism.

Despite these criticisms, the use of grounded theory principles has enjoyed resurgence over the past couple of decades (Grbich, 1999). However, rather than using pure grounded theory principles, a variety of modified approaches have been adopted. For example, Whiteley (2000) has suggested that a modified grounded theory approach should be used in the business setting to overcome the impact of institutional embedded meaning on theory generation. The approach proposed by Whitley (2000) has been adopted for this study.

3.6.1　The Grounded Research Approach

The expression grounded research is a term conceived by Whiteley (2000) to describe a qualitative research approach that is mostly, but not completely based upon the grounded theory principles formulated by Glasser and Strauss. The approach is particularly useful in the business context suggests Whiteley (2000), as in this setting the principles and procedures of grounded theory are usually only partially met. As business research usually begins with a defined business problem or issue and organisations have grand meaning entrenched in their structures, systems and processes, constrained emergence and preconceptions tend to occur (Whiteley, 2000). Whiteley (2000) maintains that although it is possible to conduct generative qualitative research using grounded theory principles, a faithful adherence to grounded theory practices is not possible.

3.6.2　Applying the Grounded Research Approach

Whilst this research makes use of the generative aspects of grounded theory as developed by Glaser and Strauss, it also acknowledges that researching an issue within a business context will require some modification to the process (Whiteley, 2000). The pure grounded theory approach supposes that preconceived ideas will prevent development of the research or imposing frameworks may block awareness

of emerging concepts (Holloway, 1997). However, by adopting a grounded research approach for this study, the researcher needed to acknowledge that institutional structures and functions within the health system could impose a framework upon the data (Whiteley, 2000).

3.7   Choosing a Topic that Requires Investigation

Before settling upon a 'question that needed to be answered' the practical aspects of choosing a topic to be investigated needed to be considered. Firstly, the research question needed to be framed in such a manner that it could be researched rather than simply being answered by a yes or no. The research would need to result in findings and outcomes. 'How' and 'what' questions are appropriate if a qualitative approach to the research is to be used (Holloway and Wheeler, 1996). Questions framed in such a manner "enable initial forays into the topic to describe what is going on" (Creswell, 1998:17).

The chosen topic was considered relevant, as devolving managerial responsibility to doctors in the context of new public management initiatives had become the new operational paradigm for hospital management. The concept of clinical directorates had been adopted worldwide with the promise that hospitals that embrace it can be run more efficiently and effectively. The philosophy of devolving management to doctors with the implementation of clinical directorate structures has continued to remain relevant throughout the course of this study.

The study was considered feasible in that the primary resource would be the researcher. The only limiting factor would be the amount of time that was required to put into the research process. Access to participants was not anticipated to be an issue. However, being an employee of one of the hospitals in the study made one wary of the reception that would be received. It was acknowledged that the interview process involved questioning that could be considered by some participants to cover sensitive issues. At the researcher's hospital, it could be thought that questions were being asked above the researcher's station. At the other two hospitals, the researcher could be perceived to be a 'spy'.

Having been involved in the public health system for 18 years prior to the commencement of this study, the comings and goings of various organisational structures have been witnessed by the researcher. At the time, the most recent 'structural innovation' was the implementation of clinical directorates. Seeing doctors intimately involved in management for the first time was intriguing. From a personal perspective, it raised the question of what would be required from these doctors to perform well in a management role? From this initial thought, a more focussed and better-defined research problem was developed.

3.8   Summary of the Problem

This study primarily focuses upon doctors who are employed as Clinical Directors in Western Australian public teaching hospitals and the situations in which they work. It seeks to discover and provide an understanding of how these doctors can perform their roles well. It does this by examining their perceptions of the topic as well as those of their Chief Executives, management teams and colleagues.

3.9   The Research Question

In qualitative research, the research question often undergoes an ongoing process of formulation and modification (Holloway, 1997). As a consequence, the researcher would need to approach the research question with an open mind should the data dictate that other questions were being answered. Flexibility and a preparedness to adapt the initial research question were necessary (Holloway, 1997). More specifically, by using a grounded approach to this research, one would need to be prepared for the research question to be developed from the data (Noerager Stern, 1985). A grounded approach, as described by Noerager Stern (1985), is a method for searching out factors. As a consequence, the study question becomes:

> ""What are the factors involved in X?" The final refined question comes at the end of the study, when you have discovered the factors which the problem is involved, and perhaps have related those factors to solutions."
>
> (Noerager Stern, 1985:153)

Having identified a topic and subsequent issue that required investigation, a first-draft research question was developed. It was based upon an overview of the literature that focussed upon the managerial leadership of Clinical Directors and the factors that influenced or inhibited their leadership. The question was:

How do clinicians who occupy Clinical Director or equivalent positions in the Western Australian public teaching hospital system, exert influence through managerial leadership upon the delivery of healthcare in their directorates?

It was soon realised that this question was quite presumptive. It presupposed that managerial leadership would be a major factor in determining how well a Clinical Director performed their role. It became apparent that the preliminary literature search had led rather than advised. Noerager Stern (1985) made a similar finding. She discovered that for those who use grounded research techniques, preliminary literature searches can be disadvantageous in that they can:

- Lead to prejudgement and the premature closure of ideas and research inquiry.
- Be focussed in the wrong direction.
- Consist of inaccurate data or materials.

The question as to whether a preliminary literature review should be performed prior to commencing a qualitative study is an interesting one. Whilst some scholars advise against any form of preliminary literature search in case of invalidation, others believe it to be essential so that old research is not re-covered. It ensures that new answers are provided for new questions (Holloway and Wheeler, 1996). Whichever the case, Holloway and Wheeler (1996:24) recognise that a researcher's mind is never a "blank canvass". They advise that:

> "Although it is inappropriate to start with a fully developed
> theoretical model and an in-depth literature review, there is a danger
> in starting without any prior idea of what has already been done in
> the field. The introductory literature review (or overview) should not

be seen to lead to *a priori* assumptions or the researcher could be accused of contaminating the data or their own interpretation."

(Holloway and Wheeler, 1996:24)

In acknowledging this advice, it was decided that a broader more open research question should be developed. It was:

What are the perceived dimensions of efficiency and effectiveness of a Clinical Director in Western Australia's major public teaching hospitals?

Structured in the above manner, this form of research question allowed the data to be explored and generative. No change to the research question was considered necessary during or at the completion of the grounded research process.

3.10 Objectives of the Study

Based upon the perceptions of those at various organisational levels within Western Australia's major public teaching hospitals, the primary objectives of this study were:

- To examine and present a framework that describes the dimensions of an efficient and effective Clinical Director in a devolved management structure.

- To review the findings against the literature on doctors in management.

3.11 Assumptions Underlying the Study

The key assumption that underlies this study is that:

The dimensions of efficiency and effectiveness of Clinical Directors will not be influenced by the differing organisational structures that exist within each of the Western Australian major public teaching hospitals.

Such an assumption is necessary since none of the hospitals in this study have exactly the same organisational structure. Whilst each has adopted a clinical directorate structure, their precise structures vary upon the theme.

3.12 Criteria for Qualitative Research (Rigour)

Rigour, as defined by Grbich (1999:61) is…

"… the researcher's attempt to use as tight a research design as possible."

Using the term "as tight as possible" in this definition clearly acknowledges that achieving rigour in qualitative research can be difficult. The main reason, suggests Whiteley (2002), is that the researcher is the primary instrument of data collection. The key to rigour is replication. However, with elements of subjectivity, the extent to which studies can be replicated using qualitative methods has been the basis for debate among scholars for many years.

In recognising that objective reality and subjective experiences can co-exist within research data, qualitative research must use different approaches to ensure its validity and reliability (Holloway and Wheeler, 1996). Whilst quantitative research looks at rigour in terms of objectivity, validity and reliability, qualitative research uses concepts such as trustworthiness, decision trails and triangulation to demonstrate rigour (Grbich, 1999),

3.12.1 Trustworthiness in the Constructivist Paradigm

Trustworthiness is an important concept in the examination and critical analysis of a qualitative study (Holloway and Wheeler, 1996). To be trustworthy, the research must clearly present, clarify and justify both the chosen methodology and the data analysis. In determining the trustworthiness of a qualitative study, Holloway and Wheeler (1996:163) believe two important questions must be answered:

1. Can the research be audited properly (the trustworthiness established)?
2. Are the actions of the researcher, influences on them and events that occur during the research clearly demonstrated (the decision trail shown)?

With this study, it is believed that a clear explanation of the methodology and careful following of the grounded theory principles of analysis outlined by Glaser & Strauss (1967) will allow subsequent researchers to be able to replicate the interview components of this study, when performed in a different setting.

3.12.2 Criteria for Establishing Trustworthiness

Guba and Lincoln (1985) suggest that the concepts of credibility, transferability, dependability and confirmability can be used to establish the trustworthiness of a qualitative study. The following table makes a comparison of these constructivist concepts with those used in the positivist paradigm.

Constructivist	Positivist
Credibility	Internal Validity
Transferability	External Validity
Dependability	Reliability
Confirmability	Objectivity

Table 3.1   Trustworthiness in the Constructivist and Positivist Paradigms
Source: Patton (1990:546)

3.12.2.1 Credibility

Guba and Lincoln (1985) suggest that there are a number of ways in which the credibility of a qualitative research study can be demonstrated. Methods include prolonged involvement, persistent observation and triangulation.

Prolonged involvement in a setting gives a study greater depth through an improved understanding of the context and the building of trust with participants (Holloway and Wheeler, 1996). Given the researcher's employment in a public teaching hospital, prolonged involvement in the setting was not a difficult task. What did prove to be difficult, was maintaining an emic (insider) perspective whilst at the same time trying to bracket one's "life world" (Whiteley, 2002:14). As an 'insider', it was believed that the researcher's clinical and managerial background helped to engender a sense of integrity with the participants.

Persistent observation equips the researcher with the ability to select the most relevant and representative issues to be examined (Holloway and Wheeler, 1996). It is believed that the extended period of data collection provided insight and the capacity to focus upon the issues being raised by the participants.

Triangulation is a technique used by qualitative researchers to validate and cross-check their findings. It does this by using a combination of different data sources such as observation, interviews and document analysis It is a valuable technique in that the strengths of one approach can compensate for the weaknesses of another (Patton, 1990).

The following figure demonstrates how three methods of triangulation were used in this study. Firstly, the data were collected across three different sites. Secondly, the triangulation of interview data from the three main categories of participants allowed the data from each of these groups to be checked against the other. Thirdly, documentary information by way of newsletters and memos were collated and compared with the interview data. When combined, these three methods present a strong argument for credibility of this research.
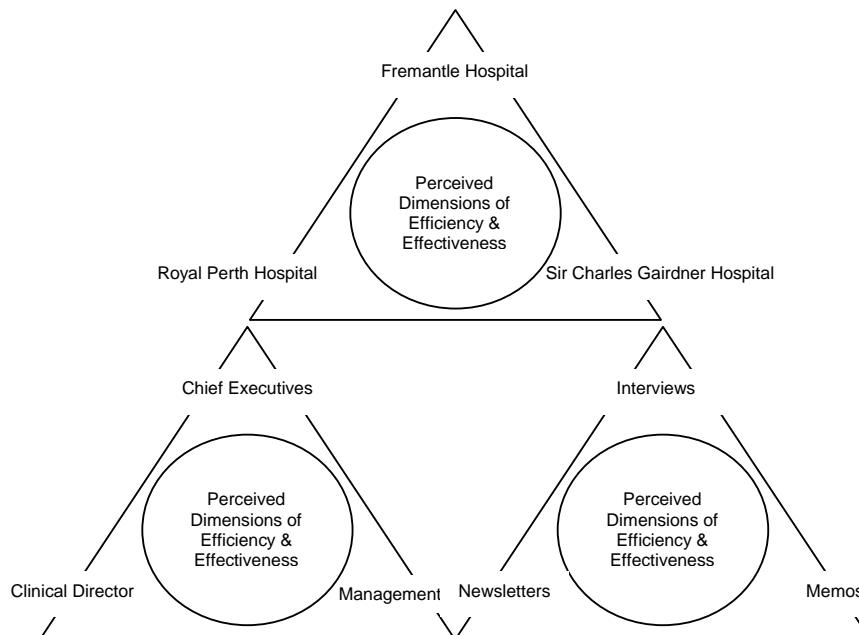
Figure 3.4   Triangulation of Data Sources

In this study, interview questions and a biographical data sheet were distributed among academics that work in the fields of organisational behaviour and human resource management for critiquing prior to testing. Advised changes were made. To verify the credibility of the interview questions and biographical data sheet, an initial interview was performed with a recently resigned member of a clinical directorate management team. The responses were assessed in order to determine the credibility and dependability of the instruments. At the conclusion of the initial interview, the interviewee was asked to comment on the questions and interview process. Some small changes to the interview process were made.

Finally, credibility can also be looked at in terms of the researcher's credibility. Polit and Tatano Beck (2004:434) describe it as…

"… the faith that can be put in the researcher."

Being the collection instrument as well as the creator of the analytic process, it is important that the qualitative researcher is up front about their qualifications, experiences, personal connections to the participants and reflections upon the topic (Polit and Tatano Beck, 2004). To this end, a statement outlining the researcher's involvement with clinical directorates is included in Appendix 1.

3.12.2.2 Transferability

Transferability is the extent to which the findings of a study can be transferred to a different setting or context (Polit and Tatano Beck, 2004). In other words, can the findings of the study be transferred from a representative sample to the general population? The different methods of sampling used in qualitative research make it difficult to accept that the findings they produce can be generalised (Holloway and Wheeler, 1996). The burden of proof for transferability therefore lies with the researcher (Polit and Tatano Beck, 2004). 'Thick description' is a technique by which the researcher can demonstrate transferability. This involves providing a detailed description of the study's time, place, context and culture (Morse and Richards, 2002; Charmaz, 2004). By providing a full account of the contextual

framework of this study, (see Chapter 4), future researchers can determine if the specific knowledge found from this group and setting can be transferred to another.

3.12.2.3 Dependability

The dependability of qualitative data is determined by its stability over time and over conditions (Polit and Tatano Beck, 2004). It is best demonstrated through documentation of the logic used throughout the research process and the decisions made on method (Guba and Lincoln, 1994). This process is known as an 'audit' or 'decision' trail (Holloway and Wheeler, 1996; Whiteley, 2002). By this chapter's explicit description of how standard decisions on theoretical, methodological and analytical processes were followed, the dependability of this study is demonstrated (Holloway and Wheeler, 1996).

3.12.2.4 Confirmability

Confirmability refers to the objectivity and neutrality of the study data. This study would be considered confirmed if two or more independent reviewers could agree on the data's accuracy, relevance and meaning (Polit and Tatano Beck, 2004). The process of auditing can also substantiate confirmability. The following documents are available should an auditor be required to review and confirm this study:

- Raw data (interview transcripts)
- Analysed data (findings)
- Formation of findings (themes, codes and categories)
- Process notes (design strategies and procedures used)
- Intentions of the study (proposal and expectations)
- Instrument development information (interview schedule, early interviews and collection strategies)
- Data reconstruction strategies (report drafts)

(Holloway and Wheeler, 1996; Polit and Tatano Beck, 2004)

3.13 Data Collection

Creswell (1998) proposes that data collection should comprise a series of interrelated activities aimed at gathering suitable information to answer emerging questions. The process that was followed in this study is illustrated by the figure below. It consisted of identifying the hospitals that could participate in this study, seeking permission to conduct interviews with staff, making contact with potential participants and getting agreement to participate, conducting interviews and collecting documentary data, making field notes, transcribing interviews and storing data.
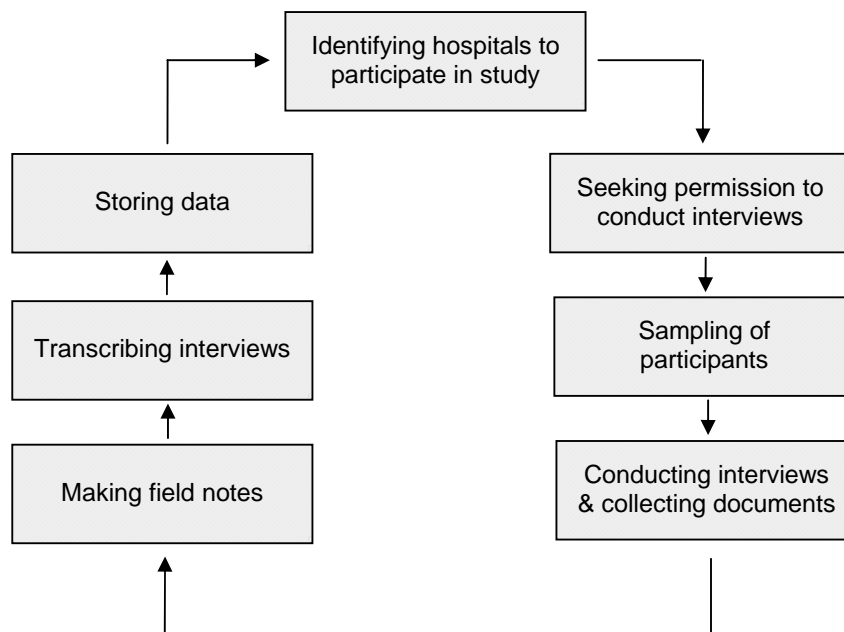
Figure 3.5   Data Collection Process
Adapted from Creswell (1998:110)

3.14 Data Sources

The major source of data for this research was the recorded interviews with 3 Chief Executives, 13 Clinical Directors, 12 Nurse Managers, 9 Business Managers and 2 Department Heads at the three major Western Australian public teaching hospitals. Those hospitals were: Fremantle Hospital, Royal Perth Hospital and Sir Charles Gairdner Hospital. A fourth Western Australian public teaching hospital (The Woman's and Children's Hospital) was also approached to participate in the study.

Unfortunately, participation was declined as the hospital was in the course of a major change process.

It was proposed that the number of interviews would be increased if either the supervisor or researcher believed that concepts were continuing to emerge. However, following the conclusion of 39 interviews it became apparent that the emerging themes were exhausted.

3.15 Sampling

Sampling was performed using the technique of 'theoretical sampling' first described by Glasser and Strauss (1967). As described by Glasser (1978:36), theoretical sampling is:

> "… the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses the data and decides what data to collect next and where to find it, in order to develop the theory as it emerges. This process of data collection is 'controlled' by the emerging theory."

Unlike other forms of sampling that are planned beforehand, theoretical sampling is an ongoing part of data collection and analysis that directs the researcher towards further selection of participants (Goulding, 2002).

Initial decisions about the sample are based upon a general understanding of the area being studied (Chadwick et al, 1984). In this study, the first few participants to be interviewed were 'purposively' solicited. Using the researcher's own experiences and knowledge of the topic to be investigated, the researcher chose initial participants that were felt to represent the population being studied. This initial decision on sample was the only one that could be pre-planned, as the selection of all other data sources was controlled by the emerging theory (Benton, 1996). The simultaneous collection and analysis of data directed where to sample next.

Using grounded theory principles, the process of determining who would participate in the study continued with the 'open coding' of data. This process (which is described later) continues until reoccurring themes appear in the data. The sampling then becomes more selective to specifically look at the issues emerging from the data. For example, initial participants in the study included Heads of Department. It was soon discovered that although useful, the issues emerging from these participants were quite superficial compared to the issues that arose from those who were more closely affiliated with the Clinical Directors. It was therefore decided not to persist with Heads of Department, but rather, to focus the sample upon participants from directorate management teams.

The order in which the category of participant were interviewed (Chief Executive, Clinical Director, Nurse Manager and Business Manager) was random. Interviews were firstly conducted at Fremantle Hospital. Royal Perth and Sir Charles Gairdner Hospitals followed thereafter. This order was chosen largely for convenience rather than any other reason. As new theory continued to be generated, the sample continued to grow. The data from participants at each successive hospital was used to not only generate new theory, but also for comparative purposes. The sample was considered complete once 'saturation' occurred. That is, no new patterns or concepts emerged from the data (Goulding, 2002).

3.16 Qualitative Interviews

Interviewing plays an essential role in the data collection phase of a grounded research approach (Creswell, 1998). The aim of the interview, writes Grbich (1999:85):

> "…is to gain information on the perspectives, understandings and meanings constructed by people regarding the events and experiences of their lives."

The terminology used to describe qualitative research interviews can take a variety of forms, but in general, they are usually referred to as structured, unstructured or semi-structured (Whiteley et al, 1998).

The semi-structured interview, suggests Polit and Tatano Beck (2004:342) is used when qualitative researchers "know what they want to ask, but cannot predict what the answers will be". Under this scenario, the researcher's role is structured, whilst the participant's is not. With the semi-structured interview, the researcher designs a series of questions that are to be covered by each participant. The function of the researcher is to encourage the participant to talk freely on each question asked. It enables participants to respond freely in their own words and in as much detail as they wish (Polit and Tatano Beck, 2004). The semi-structured rather than unstructured interview technique was chosen, as this study was not completely exploratory in nature

3.16.1 Assumptions Underlying the Qualitative Interview

In using a semi-structure interview process for this research, a number of assumptions will be made. Based upon the discussion found in Grbich (1999) and Whiteley et al (1998) they are:

- The interviewee and researcher will understand one another and that the signs and symbols used will be meaningful to each. That both will share the visual images evoked and the interpretations applied.
- The personal interaction between the participant and researcher will not result in bias.
- Memory bias, selective memory and poor recall will be overcome by triangulation.
- The information gained from the interviewees will be accurate.
- The participant will be able to provide information that is relevant, reliable and able to be interrogated.
- The response to the researcher's questions will bear some relation to the 'truth' of the participant's understanding and knowledge of the issue.

3.16.2 The Interview Process

Creswell (1998:123) sees the grounded research interview as a process that consists of a series of steps. They include:

1. Identify interviewees based on purposeful **sampling** techniques (§3.15).
2. Determine the most practical **interview format** that will gather the most useful information to answer the research question (§3.16).
3. Design the **interview schedule** (§3.16.3).
4. Obtain **informed consent** from the interviewee prior to participation (§3.18).
5. Identify a **place** for conducting the interviews (§3.19).
6. Complete the interview within the **time** specified, be respectful, courteous and offer little advice (§3.20).
7. Use an appropriate **recording device** (§3.21).

The stepwise process described by Creswell (1998) for organising a qualitative research interview was followed.

3.16.3 Designing the Interview Schedule

In keeping with a grounded approach to data collection, the interview questions were general in nature, rather than tightly-framed to pre-conceived hypotheses. As suggested by Charmaz (1990), the interview questions were ordered and framed according to five different kinds of questions: (1) short fact-sheet, (2) informational, (3) reflective, (4) feeling and (5) ending.

The short-fact sheet questions were intended to be neutral, factual and limited to the necessary information. Informational questions established chronology, types of events and degrees of awareness. Reflective and feeling questions, which take the form of 'how' type questions, were directed at the participant to elicit their own personal perspective on issues. They were designed to elicit the narrative of the participant's story with only minimal framing by the researcher. Ending questions were designed to complete the interview on a positive note (Charmaz, 1990).

A first draft of the interview schedule was devised. It contained 24 semi-structured questions. Following critical comment and subsequent supervisor discussion, the draft schedule was reviewed and altered with the total number of questions being reduced.

3.16.4 Final Interview Schedule

The final interview schedule consisting of 22 semi-structured questions is presented in Appendix 2.

3.16.5 Preliminary Interview

The revised schedule was used in the preliminary interview. Upon debriefing, the participant indicated that the questions were interesting and that the interview schedule was easy to follow. The only criticism being that the definitions of efficiency and effectiveness required some reflection and were difficult to ponder when recited by the interviewer. It was suggested that each definition could be written on a sheet of paper and handed to the participant to help focus on their response. This recommendation was implemented and the following definitions were handed to each participant when the questions on efficiency and effectiveness were asked.

<div style="border:1px solid #000; padding:10px; background:#eee;">

Efficiency – utilising resources appropriately

</div>

<div style="border:1px solid #000; padding:10px; background:#eee;">

Effectiveness – the successful achievement of organisational goals

</div>
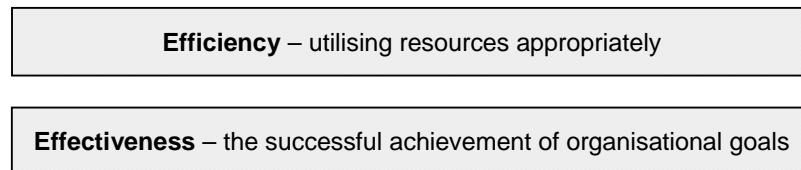
Figure 3.6   Definition Contemplation Cards

3.17 Types of Data Collected

Data were collected via a combination of semi-structured interviews, biographical questionnaires and document searches.

3.18 Securing the Interviews and Informed Consent

Permission was sought from the Chief Executives of Fremantle Hospital, Royal Perth Hospital and Sir Charles Gairdner Hospital for the study to proceed (Appendix 3). Written permission to conduct interviews was received from the Chief Executive of Royal Perth Hospital (Appendix 4) whilst the Chief Executives of Fremantle and Sir Charles Gairdner Hospitals verbally granted permission. The potential participants were personally contacted and invited to be involved in the study. All interviews were carried out at a time and place convenient to both the participant and the researcher.

Each of the participants gave their informed consent to be involved in the research prior to the interview proceeding. Their consent was recorded on audiotape.

3.19 Location of Interviews

All of the 39 interviews were performed at the hospital where the participant was employed. The majority of interviews were held in the office of the participant. A small number were undertaken in meeting rooms where privacy could be assured.

3.20 Length of Interviews

On average, the interviews lasted approximately 1 hour. In some cases, the interview was interrupted due to phone calls to the participants. Each participant was treated with professional respect and courtesy. The results obtained from other interviewees were not discussed with the subsequent participants.

3.21 Recording Device

All interviews were recorded using a micro-cassette recorder and later transcribed verbatim. The recorder contained a multidirectional microphone that allowed the device to be placed (usually on a desk) between the participant and researcher. Although each participant was advised that they could turn the recorder off should

they wish to discuss sensitive issues, none of the 39 participants elected to do so. Total anonymity was maintained, with no identification appearing on either the recording or transcription of the interview.

3.22 The Interviews

The interviews started with a preamble thanking the participant for contributing to the study. It was pointed out that participation in the study was completely voluntary and should a participant wish, they could withdraw from the study at any stage.

Assurances were given that all of the discussion would be held in the strictest of confidence and that no individual would be identified in the analysis and write-up of the study.

As discussed previously, the interviews were semi-structured. There was no limitation on time. All questions were open-ended and allowed for further inquisition. Probing statements such as 'why do you believe that?', 'why is that your perception?' 'tell me more…' or 'can you think of an example?' were used throughout the interviews.

To minimise bias and the possibility of collusion, participants were asked not to discuss the content or methodology of their interview with other staff members. At the conclusion of each interview, permission was sought to later contact the participant should clarification or elaboration be required. As such, three participants were subsequently contacted to provide missing details on their biographical data sheets.

3.23 Biographical Data Sheet

Each participant was asked to complete a biographical data sheet to provide information on age, sex, span of control within the organisation, educational background, career background and leadership experience. The biographical data sheet is provided in Appendix 5.

3.24 Documents and Literature

Relevant documents such as organisational charts, newsletters and memos that either validated or expanded upon the information obtained at interview, were collected and analysed. Literature searches that related to the research's evolving concepts and themes were continually performed.

3.25 Period of Data Collection

Data was collected over a 19-month period between April 2002 and November 2003.

3.26 Data Analysis

In following grounded research principles, it is important that the processes of data collection, data ordering and data analysis are interrelated. The following schema was used in the course of this study.
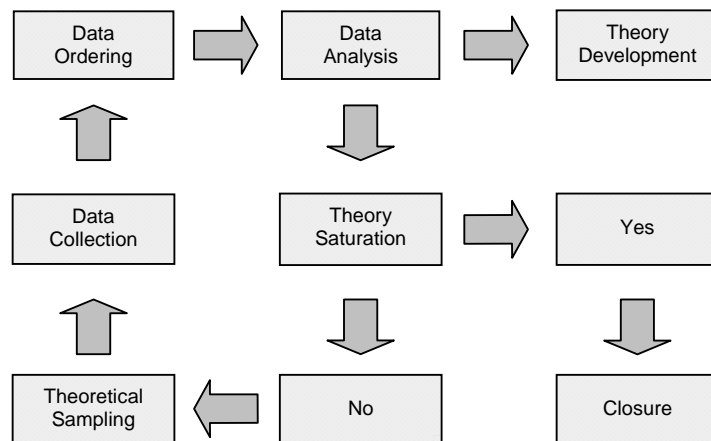
Figure 3.7   Process of Data Collection, Ordering and Analysis
Adapted from Pandit (1996)

Although the data collection techniques in the grounded research approach are the same as those in most other forms of qualitative research, it is the data analysis phase of this methodology that distinguishes it from others. In using this methodology, the data that were collected in this research underwent an extremely rigorous process.

Following the advice of Stevens et al (1993), categories and emerging concepts were reflected upon many times over before a firm theoretical proposition was made.

3.26.1 Analysis Strategy

Marshall and Rossman (1995:111) describe data analysis as being:

> "… the process of bringing order, structure and meaning to the mass
> of collected data."

The guiding principle used to analyse the data for this study was emergence. By carefully following grounded research principles, data were transformed and subsequently reduced to build categories. It was through the emergence of these categories that theory eventually evolved.

Following preparation of the data for analysis, the data underwent a structured coding process that involved open coding (initial and focussed), theoretical coding and memo writing.

3.26.2 Preparing Qualitative Data for Analysis

Each recorded interview was transcribed verbatim into a word processing package (Microsoft Word Version 7), making sure indications are made when pauses and emphasis occur. The transcript was typed in a format suitable for data management using QSR•NUDIST Qualitative Research Software (QSR•NUDIST, 1996).

3.26.3 Content Analysis

Content analysis of the interviews was performed using grounded research techniques (Whiteley, 2000). That is, the analysis followed as closely as possible the grounded theory principles of theory generation that were first described by Glasser and Strauss in 1967. However, as the research question was based within a business setting, the principles and procedures of the grounded theory method were only partially met (Whiteley, 2000).

3.27 The Coding Process

3.27.1 Data Coding and Categorising

The grounded research method is distinguished from other qualitative approaches to research in that both data collection and data analysis proceed simultaneously. As such, the data analysis phase of this research followed the ensuing framework.

3.27.1.1 Open Coding

The initial phase of the analytic method involved the open coding of the data. This first analytic step involved the categorising and sorting of data. The process involves breaking down the data into discreet parts, closely examining and comparing those for similarities and differences (Strauss and Corbin, 1998). Here, data were examined line by line with the objective of being able to label, separate, compile and organise them into meaningful categories (de Burca and McLoughlin, 1996).

As advocated by Glasser (1978), the open coding process was divided into two phases: initial coding and focussed coding.

3.27.1.2 Initial Coding

Initial coding sought to summarise, synthesise and sort the many observations made of the collected data. Here, the aim was to define and discover meaning within the data, making sure not to force the data into codes, but rather make codes that fit the data. Glasser (1978) suggests that open coding can be achieved by looking at each line of data and reflecting upon a series of general questions such as:

- What are these data a study of?
- What category does this incident indicate?
- What is actually happening in the data?

Strauss and Corbin (1998) offer a simpler framework. They suggest that the researcher should simply ask who, what, when and where of each line.

3.27.1.3 Focussed Coding

The process of focussed coding followed the initial coding stage. The purpose of focussed coding was to build and clearly clarify derived categories by re-examining all the data associated with them. In other words, limited sets of codes that were developed in the initial stage were then applied to large amounts of data. The coded data were compared with other data and assigned to categories according to obvious fit. This process, labelled by Glasser (1978) as the constant comparative method, saw coded data constantly confronted and verified by new data.

3.27.1.4 Theoretical Coding

After developing a set of focussed codes into categories, the process of developing an emergent model from the data began.

Stern (1980) identified three major steps that assist in developing the emerging theory. They were reduction, selective sampling of the literature and selective sampling of the data.

The process of reduction was a vital step in discovering the major processes, or what Glasser and Strauss (1967) term 'core variables' of the data. Essentially this step tried to link everything together. Categories were clustered together with other similar categories in anticipation that linkages would emerge (de Burca and McLoughlin, 1996).

The integration of categories at a higher level required conscious decisions to be made about which categories reflect significant processes, relationships, events or issues that were worthy of recognition. Two analytical processes that helped to raise categories to a conceptual level were constant comparison and continued questioning (de Burca and McLoughlin, 1996).

Both these processes were achieved through what Glasser (1978) terms theoretical sampling and selective sampling of the literature. Essentially, the conceptual

categories derived were confronted with more data in order to improve definitions, delineate their properties, explicate their causes, demonstrate the conditions under which they operate and spell out their consequences (de Burca and McLoughlin, 1996).

This process consisted of two components. Firstly, further data from the literature, documents and memos were collected to identify and elaborate the properties of the conceptual categories. Secondly, the resulting conceptual framework was tested by collecting data that either provided or did not provide support for the framework. This process continued until the number of categories that developed was exhausted (de Burca and McLoughlin, 1996).

To conclude the process of theoretical coding, relevant literature was scrutinised, selected and used as data in order to help explain the emergent theory. As suggested by de Burca and McLoughlin (1996), care was taken to explain the theory rather than the theory be derived from it.

3.27.1.5 Memo Writing

An important activity that was pursued throughout the coding process was the writing of memos (Crabtree and Miller, 1992). As Corbin and Strauss (1990:10) suggest:

> "Writing theoretical memos is an integral part of doing grounded theory. Since the analyst cannot readily keep track of all the categories, properties, hypotheses and generative questions that evolve from the analytical process, there must be a system for doing so. The use of memos constitutes such a system. Memos are simply not "ideas". They are involved in the formulation and revision of theory during the research process."

Hence when an 'idea' was realised the coding was interrupted in order for the memo to be written down. According to Glasser (1978) this process accomplishes at least 5 important aspects of generating theory:

- It raises the data to a conceptual level.
- It develops the properties of each category.
- It presents hypotheses about connections between categories and/or properties.
- It begins to integrate the connections with other categories to generate theory.
- It begins to locate the emerging theory in relation to other theories.

At the completion of this process of analysis, the memos were sorted and integrated. In doing so, categories became easily distinguishable from each other and interconnecting relationships became apparent.

At this stage the core variables began to emerge. Analysis ceased when all the categories were saturated. That is, when no new information was received that further explained the emerging hypotheses surrounding the dimensions of efficiency and effectiveness of Clinical Directors.

3.28 Storage of Data

After the interview tapes were transcribed and entered into the research database, all tapes were securely stored in case they were needed for future review. To prevent the accidental loss of data, back-up files were stored on DVD and pen drive. Original data, including biographical data sheets, will be retained for a minimum of five years in accordance with the University's policy on this matter.

3.29 Ethical Issues

This research was conducted in accordance with Curtin University's ethical guidelines and policies. Thus, the following ethical considerations were followed:

- Interviews were only performed after the Chief Executive of each participating organisation granted permission.
- The purpose and objectives of the study were explained to each participant.
- Participation in the study was entirely voluntary.

- Each participant in the study was assured total confidentiality and granted assurances that only the researcher would know their identity.

- Information that could identify participating organisations which was considered commercially sensitive by the researcher or supervisor was not published.

- Where a Secretary was used to transcribe recorded interviews, the importance of respondent anonymity was explained and a statement of confidentiality signed.

3.30 Chapter Summary

The purpose of this study is to explore the dimensions of efficiency and effectiveness of Clinical Directors in Western Australia's public teaching hospitals. Given the nature of the research problem as well as the ontological and epistemological stances of the researcher, a qualitative approach was adopted. The intention to derive 'meaning' from the Chief Executives, Clinical Directors, Nurse Managers, Business Managers and Heads of Department who participated in this study was a key assumption that inspired this research.

Being set within a constructivist paradigm, this research utilised a grounded research approach to data collection and analysis. It assumed that the dimensions of efficiency and effectiveness would not be influenced by the variations in clinical directorate structures that existed across the three public teaching hospitals participating in this study.

The rigour of this study was justified by establishing the criteria for trustworthiness through credibility, transferability, dependability and confirmability.

The data collection process for this study involved identifying the hospitals that could participate in the study, seeking permission to conduct interviews, choosing and contacting appropriate participants, conducting interviews, collecting documents, making field notes, transcribing interviews and storing data.

Data was collected via a series of semi-structured interviews, biographical data sheets and relevant documents. The interview schedule was carefully designed using a

grounded approach to data collection. A total of 39 interviews were conducted across the three hospitals that participated in the study. Thirteen interviews were conducted at each hospital. The data collection period lasted 19 months and occurred between April 2002 and November 2003.

Data management was assisted by the use of qualitative research software - QSR•NUDIST. Content analysis of the data was performed using grounded research techniques that included open, initial, focussed and theoretical coding as well as memo writing.

A description of this study's context follows in Chapter 4. The findings that have been derived from the described methodology are contained in Chapter 5.

Chapter 4 Context

4.1 Introduction

This chapter provides the contextual setting in which the data collection for this research occurred. In doing so, it offers an overview of the Australian healthcare system as well as a brief description of the health system in Western Australia. Aside from describing the structure of Western Australia's health system, the chapter also discusses the issues that confronted the health system just prior to the era of clinical directorates. The period that the discussion covers is from the beginnings of the Health Department of WA in 1984 through to the time the interviews commenced in 2002.

This chapter also discusses the development of clinical directorates at the three major teaching hospitals in which the interviews took place. It provides an overview of each organisation, its structure and the process by which their clinical directorates were formed.

4.2 The Australian Healthcare System

Australia has a universal healthcare system that involves a mix of both public and private sectors. The public sector has the involvement of both Federal and State governments. The Federal government is primarily responsible for health policy and national issues such as public health and medical research. The States on the other hand are principally responsible for the delivery and management of public health services (Health and Aged Care, 2000).

As a result, the services the States provide include in-hospital acute care and in-hospital psychiatric services as well as community and public health services such as school, dental, maternity and child health (Health and Aged Care, 2000).

The private sector mostly provides private hospital and ancillary medical services. In Australia, either corporate operators or not-for-profit religious organisations own private hospitals. Whilst private hospitals of the past tended to offer only non-emergency care and elective surgery, private hospitals today are providing increasingly complex and technologically advanced services (Duckett, 2002).

4.3   Private Healthcare

Australia also has an extensive private healthcare system that works alongside the public system. The private system is largely funded by private health insurance funds with additional contributions from patients. The Federal government has strongly supported the private health sector both philosophically and financially (Health and Aged Care, 2000). The Federal government has introduced a financial incentive (a 30% subsidy) for those who take out private health insurance and a financial penalty (a 1% Medicare surcharge) for those who do not (Segal, 2004).

Depending upon an individual's level of cover, private health insurance contributes towards in-patient private hospital costs as well as public hospital costs when admitted as a private patient (Health and Aged Care, 2000; Medicare, 2007).

4.4   Healthcare Expenditure

According to the Australian Institute of Health and Welfare (2007), Australia spent $86.9 billion on health in the 2005/2006 financial year. This figure represents a $5.8 billion, 3.1% real increase over the previous year. This increase was below the average 5.1% real increases over the past decade.

Year	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06
%	6.0%	4.2%	5.6%	5.7%	8.4%	4.0%	5.0%	3.6%	5.3%	3.1%

Table 4.1   Annual Increase in Health Expenditure (CPI Adjusted)
Source: Australian Institute of Health and Welfare (2007:10)

The amount of $86.9 billion represents 9.0% of Australia's Gross Domestic Product (GDP). This percentage has increased from 7.5% over the past decade.
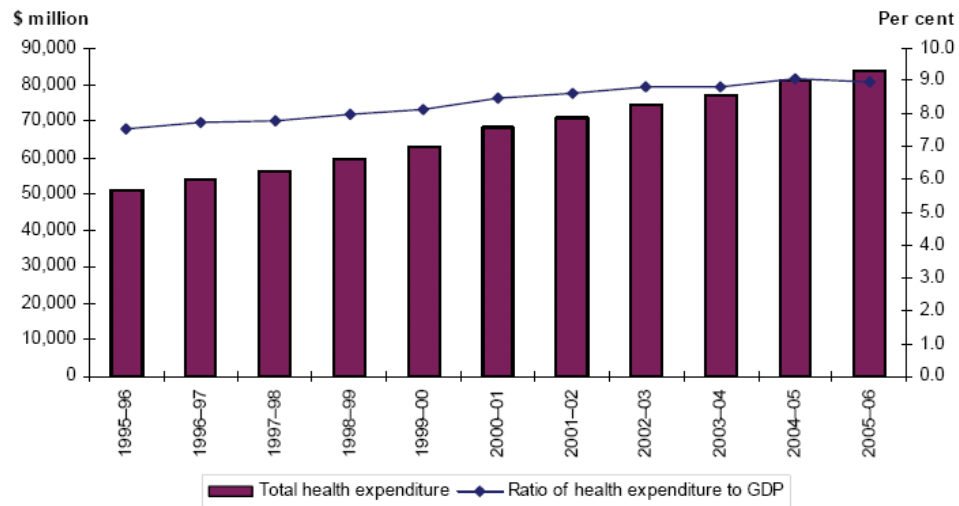
Figure 4.1   Total Health Expenditure and GDP
Source: Australian Institute of Health and Welfare (2007:10)

In 2005 real terms, Australia's ratio of total heath expenditure to GDP compares favourably when judged against other OECD nations.

OECD Country	Health to GDP%	Per Person ($A)
United States	15.3	8,833
France	11.1	4,656
Germany	10.7	4,536
Canada	9.8	4,590
Sweden	9.1	4,027
New Zealand	9.0	3,233
Italy	8.9	3,494
Australia	**8.8**	**4,121**
United Kingdom	8.3	3,759
Poland	6.2	1,196

Table 4.2   Health Expenditure as a Proportion of GDP per Person (OECD)
Source: Australian Institute of Health and Welfare (2007:80)

4.5   Healthcare Funding

Of the $86.9 billion spent on healthcare in 2005/2006, Australian governments funded $58.9 billion and the non-government sector funded $28 billion. Funding was sourced according to the following table:

Source	Amount	%
Federal Government	$37 billion	42.9%
State & Local Government	$22 billion	24.9%
Individuals	$15.1 billion	17.4%
Miscellaneous non-government	$6.6 billion	7.6%
Health Insurance Funds	$6.3 billion	7.2%

Table 4.3   Sources of Health Funding

Source: Australian Institute of Health and Welfare (2007:20)

As illustrated by the following graph, the sources of funding have remained fairly consistent over the past decade.
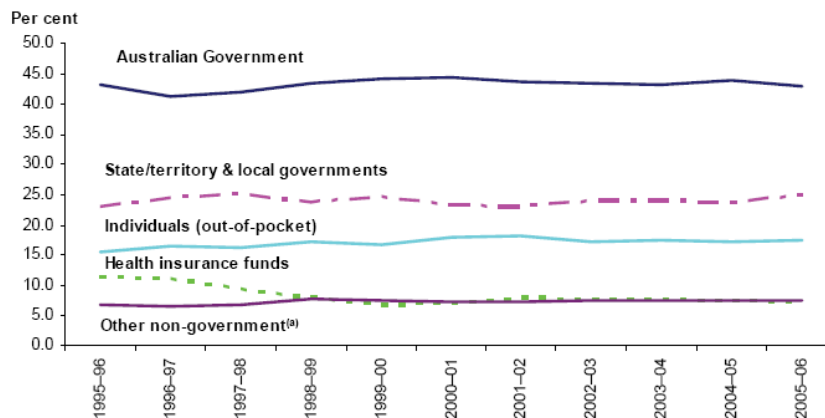
Figure 4.2   Health Funding Sources Over Time

Source: Australian Institute of Health and Welfare (2007:20)

The source of health funding varies according to the type of health service. For example, public hospital funding is made up of 48% Federal funds, 45% State funds and 7% private funds. In comparison, medical services such as outpatient visits and

pharmaceuticals are 82% federally funded with the balance paid by the patient (Lazarus et al, 1999; Duckett, 2002).

These funding responsibilities are set out in Healthcare Agreements between the Federal and State governments. The agreements describe the basis by which the Federal government will provide funding to the States over a 5-year period (Connelly and Doessel, 2000).

The source of monies used to fund health expenditure is from either general tax revenue or a universal health insurance levy – the Medicare levy.

4.6   Medicare

Medicare is a healthcare financing scheme that is both compulsory and universal in nature (Connelly and Doessel, 2000). Its origins date back to 1975 when a national health scheme known as 'Medibank' was introduced (Rossiter, 1976). The scheme was designed to provide free treatment in public hospitals, a significant rebate on scheduled hospital fees for private patients and bulk billing for outpatient services (Brooks, 1999). Funding for the programme was meant to be by way of a 1.35% levy on individuals' taxable incomes; however, this funding proposal was rejected by the Senate of the time. As a consequence, the scheme was initially funded by general tax revenue. In October 1976, the government introduced a levy of 2.5%. The programme underwent various changes over the subsequent decade and was eventually reintroduced as Medicare in 1986 (Biggs, 2004).

As it stands today, the Medicare levy is set at 1.5% of taxable income; however, this rate is really a nominal one as a levy of around 8% would be required to fund the $59 billion currently spent by government on healthcare (Duckett, 2002).

The Health Insurance Commission of Australia (HIC) administers Medicare. The fundamental characteristics of the scheme are:

- All Australians are eligible to participate.

- It provides free accommodation, medical care, nursing care, ancillary care and pharmaceuticals to patients admitted as public patients in a State-owned (public) hospital.

- Individuals are able to opt in and out of the public system whenever they choose.

- Patients can be admitted as private patients in a public hospital. If this is the case, the scheme will pay 75% of scheduled in-patient costs. Depending on their level of insurance, the remaining 25% is usually paid by the patient's private health fund.

- A schedule of fees is set by the HIC for both in-patient and outpatient services.

- Doctors are not limited to what fees they charge.

- Medicare will pay 85% of its scheduled fee for outpatient visits to a General Practitioner, Specialist or Optometrist.

- Doctors can invoice patients directly or send their invoice to the HIC for payment.

(Segal, 2004; Health and Aged Care, 2000; Medicare, 2007)

4.7 Public Hospitals

Hospitals in the public system are for the most part State funded, owned and operated. With the majority of these institutions being teaching hospitals and research centres, they offer state-of-the-art service but basic accommodation (Johnsson, 1991).

The most recent statistics show that there were 77,495 hospital beds in Australia in 2003-2004. Almost two-thirds of these beds (50,915) were in the public sector with the remaining one-third (26,580) in the private sector (Department of Health and Aging, 2006).

Since the early 1990s the total number of beds available in the public sector has declined by approximately 10%. However, bed occupancy has increased by around 7% to 85.4% (Department of Health and Aging, 2006).

Public hospitals are the primary providers of emergency and acute care, with long waiting lists for elective surgery (Johnsson, 1991). As a consequence, more Australians are choosing to receive treatment in private hospitals. According to the Department of Health and Aging (2006), separations from private hospitals increased around 40% (1.9 million to 2.6 million) between 1998/99 and 2003/04. This was over four times the 9% increase in the rate of separations from public hospitals (3.8 million to 4.2 million).

This increase in utilisation has been accompanied by cuts to public hospital budgets. Funding for public hospitals is based on case-mix using Diagnostic Related Groupings (Duckett, 2002). In-patients are categorised and placed in nominated groups according to their diagnosis. Funding is then determined according to the numbers and type of patients that are treated rather than history, politics or the resources that a hospital uses (Victorian Government Health Information, 2007).

4.8   Recent History of the Health System in Western Australia

The State's Department of Health was initially named the Health Department of Western Australia. The department was created in 1984 through the amalgamation of the Departments of Public Health, Mental Health and Hospital & Allied Services. Its responsibility is to manage the State's entire public health system (Health Department of WA, 1988).

The purpose of the 1984 amalgamation was to create a more effective and efficient health system through the integration of services, the elimination of duplication and the appropriate distribution of resources (Health Department of WA, 1990).

Whilst the objectives of the 1984 amalgamation were mostly achieved, significant barriers to full integration existed due to the continuation of an organisational structure that was based upon professional lines of authority. This structure proved to be an obstacle to the development and achievement of common policy and programme goals (Health Department of WA, 1990).

In 1988, a functional review was commissioned by the Minister in an effort to improve the efficiency, effectiveness and equity of healthcare delivery across the state (Health Department of WA, 1990).

However, aside from a change to the department's organisational structure, the recommendations of the functional review were never implemented. Instead, a Task Force that consisted of Health Department Executives, Ministerial, union, and health profession representatives was convened to look at the many recommendations made by the Functional Review Committee (Health Department of WA, 1988).

The Task Force existed for less than a year before the Minister for Health commissioned the private consulting firm Deloitte Ross Tohmatsu to perform a Health Services Review (Deloitte Ross Tohmatsu, 1991).

The review came at a time when there was considerable change throughout health industries and their environments. Just as in Western Australia, health authorities throughout the world were attempting to find solutions to the rapidly increasing demand for health services. The pressures of finite funding meant that Governments of all persuasions had to adopt measures to increase health service efficiency, set resource priorities and hold managers responsible for results (Government of Western Australia, 1991).

The specific factors that were challenging Western Australia's health system included a rising demand for services due to an aging population, an increased demand for public beds as a result of reduced levels of private health insurance and additional capital and recurrent costs borne of new medical technologies (Government of Western Australia, 1991).

The 1991 Heath Services Review suggested that Western Australia's health system's organisational and management framework was not appropriate for the future (Deloitte Ross Tohmatsu, 1991).

It commented that weaknesses such as the fragmentation of services, lack of strategic direction, informality of service planning & rationalisation, inadequate information systems, unknown costs and lack of community involvement in service development were impeding the appropriate allocation of diminishing resources (Deloitte Ross Tohmatsu, 1991).

The international response to healthcare costs and demand pressures were closely analysed to determine the best way for Western Australia to respond. By examining the health services of OECD countries such as the Great Britain, New Zealand, Canada, Norway and Sweden, a number of common responses to healthcare cost pressures became apparent. They were:

- Resources were being more explicitly allocated between competing priorities.
- The commercial provision of services was being actively encouraged.
- Health funding and management was being specifically based upon the healthcare needs of the population.
- Community expectations were being aligned with budgetary limits.
- Private health insurance was being encouraged.
- The roles of the health service purchaser and health service manager were being increasingly separated.
- Day-to-day management of health services were being increasingly devolved to area or regional authorities.
- Competitive and co-operative relationships between public and private providers of healthcare were being developed.
- Funding was being linked to specific health outcomes such as quality and volume of service.
- Heavy investment in improved information systems was being made.

Government of Western Australia (1991)

The review proposed that the problems faced by the Western Australian health system could be mitigated with the establishment of three Health Boards and the development of an area management structure. Under this arrangement the Health

Department itself would take on a more clearly defined strategic role and would no longer be primarily involved with service delivery. Instead, as the funder of health services, it would be able to use contracts and performance agreements with the Area Health Boards and private health providers to promote greater efficiencies and accountability (Deloitte Ross Tohmatsu, 1991).

It was recommended that the three health areas should closely follow the three metropolitan regions that existed at the time. That is, North, East and South. Each region included one of the three metropolitan hospitals (Deloitte Ross Tohmatsu, 1991).
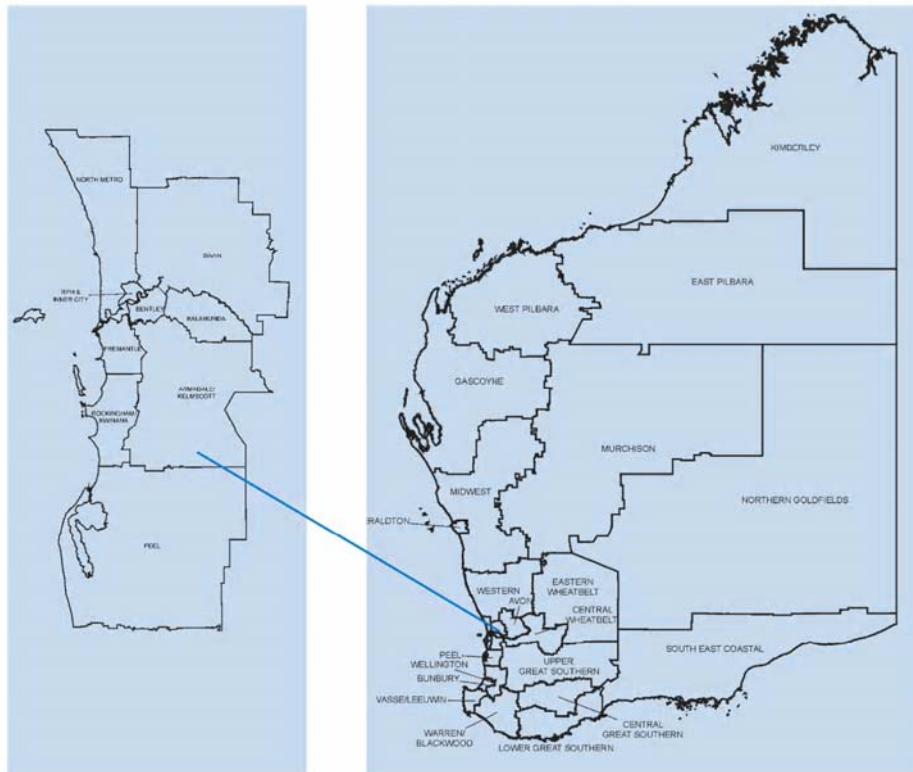
Figure 4.3   Western Australian State and Metropolitan Health Regions
Source: Health Department of WA (1999)
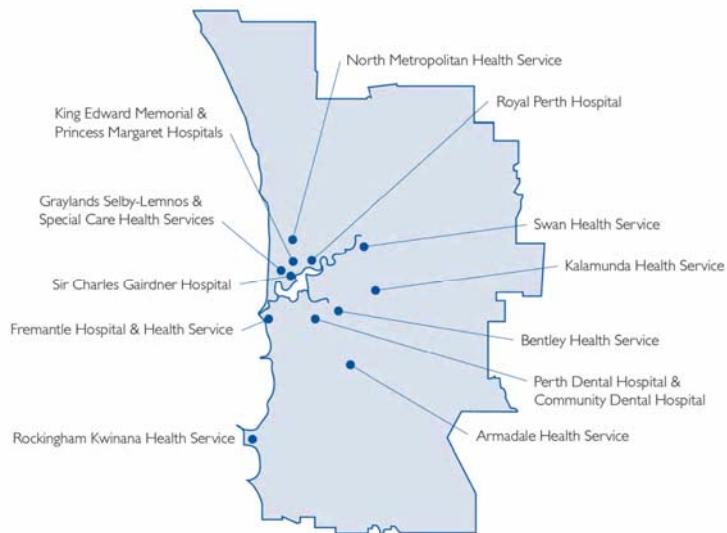
Figure 4.4   Western Australian Metropolitan Public Hospitals
Source: Metropolitan Health Services Board (1999)

The broad recommendations of the Deloitte Ross Tohmatsu report were accepted and in 1992 the Government set about implementing a series of reforms that would enact the recommendations.

Many of the reforms related to the overall structure, management, planning and funding of the State's health system. However, a proposal that was specific to the management of Perth's Teaching Hospitals was that:

> "Hospital Chief Executive Officers may wish to assign managerial responsibility for cost centres to enable better understanding and control of costs."

Government of Western Australia (1991)

This recommendation appears to be the catalyst for the systematic introduction of clinicians to management in health services in Western Australia. Following this recommendation, the three main public teaching hospitals commenced their exploration into clinical directorates.

With the aim of reducing costs and reallocating resources to the areas of greatest need, recommendations that further supported devolved management models (such as unit based budgeting) were introduced into the teaching hospitals (Fremantle Hospital, 1992).

In 1994, after less than 2 years of operation, the North, East and South Metropolitan Health Services were abolished. Significant health management reforms were again taking place. Over the coming year, a competitive market for public health services in Western Australia was to be created. The Health Department of WA was to embark upon a Funder-Owner-Puchaser-Provider (FOPP) model for healthcare services (Fremantle Hospital, 1994). Under this model, providers of healthcare such as the public teaching hospitals would contract with health funding authorities to deliver services.

The FOPP model was designed to entice hospitals to maximise throughput whilst maintaining efficiencies. The model's intent was that managers of health services would be able to concentrate on efficient and effective management whilst purchasers could focus on improving the health status of the population they purchase for (South Metropolitan Health, 1995).

Many medical staff embraced the reforms of the mid 90s by changing past practices to increase efficiencies and adopting the early stages of devolved management structures which saw clinicians take greater responsibility for budgetary outcomes (Fremantle Hospital, 1995).

Over the 4-year period between 1994 and 1997, clinical directorates were sequentially established in all of Perth's major public teaching hospitals. The process by which they were implemented and the structure that they had varied from hospital to hospital; however, a common theme across all of the hospitals was that the authority and responsibility for services was devolved to Medical Practitioners.

In July 1997, the Minister for Health announced changes to the management of Western Australia's public teaching hospitals. It involved the creation of an

overarching Metropolitan Health Services Board and the subsequent dissolution of the Boards of all the tertiary and secondary hospitals (Fremantle Hospital, 1997).

The Metropolitan Health Services Board was established for the purpose of providing better co-ordination of and improved access to hospital and health services in the metropolitan area. It was anticipated that reshaping organisational structures and implementing uniform policies across all hospitals under its jurisdiction would achieve this purpose (Metropolitan Health Service Board, 1998).

The Board existed for only 4 years and was disbanded in 2001. Towards the end of its life, it reintroduced the concept of regional health management to Western Australia's health system. In 2001, 3 regional health authorities were created to manage the day-to-day operations of the hospital catchments encompassing the Northern, Eastern and Southern metropolitan regions. A separate Woman's and Children's Health Authority was created following an enquiry into the services of King Edward Memorial Hospital (Metropolitan Health Services Board, 2000).

The suggestion of a move towards Integrated Clinical Services in the early 2000s segued well with the work that had been done by the public teaching hospitals in developing clinical directorates. An Integrated Clinical Service is the:

> "… grouping of similar, related or complementary clinical services or activities that take responsibility for the operational planning, management and delivery of designated suites of health services either across the metropolitan area or within a defined suburban catchment."

Health Department of WA (2000:32)

As with clinical directorates, Integrated Clinical Services are developed along the lines of services such as Cancer Services, Cardiac Services or Emergency Medicine & Critical Care. The only difference was that an Integrated Clinical Service would operate across all of the metropolitan hospitals and health services. Unfortunately, however, at the time data was collected for this research, Integrated Clinical Services were still conceptual.

Despite the waxing and waning of health reforms in the late 1990s and early 2000s, all the 3 major public teaching hospitals that contributed to this research persisted with their devolved management structures. The processes they followed and the structures they adopted are described in the remainder of this chapter.

4.9 Tertiary Public Teaching Hospitals

Western Australia has four tertiary public teaching hospitals. They are Royal Perth Hospital, Sir Charles Gairdner Hospital, Fremantle Hospital and Princess Margaret Hospital for Children. The first three mentioned hospitals participated in this research.

4.9.1 Royal Perth Hospital

4.9.1.1 Overview

Royal Perth Hospital is an Australian Council on Healthcare Services (ACHS) accredited 955 bed tertiary hospital. First established in 1830, Royal Perth Hospital is the oldest and largest hospital in Western Australia (Royal Perth Hospital, 1995a; Royal Perth Hospital, 2006). It now operates across two campuses: Wellington Street in the Perth CBD and Shenton Park Hospital, which is located 6 kilometres away. The Wellington Street campus is a 24-hour acute care public teaching hospital. It offers most adult major tertiary services except obstetrics (Royal Perth Hospital, 2006).

The hospital provides a state-wide referral service for burns treatment, major trauma, heart and lung transplant, bone marrow transplant, refractory epilepsy, haemophilia, spinal rehabilitation, head injury rehabilitation and interventional neuroradiology (Royal Perth Hospital, 2006).

The hospital's catchment area includes the inner city area and extends northeast through the Swan Valley region and southeast through the Bentley and Kalamunda regions (Metropolitan Health Services Board, 1999). The number of people in the

hospital's catchment area totals approximately 400,000 (Metropolitan Health Services Board, 1999).

The Wellington Street campus has on average 579 in-patient beds. An additional 190 in-patient beds are located on the Shenton Park campus (Royal Perth Hospital, 2006).

Royal Perth Hospital has approximately 80,000 admissions and 150,000 outpatient attendances each year. It has one of the busiest Emergency Departments in Australia with more than 54,000 presentations per annum. The hospital has approximately 3,800 full time equivalent positions (Metropolitan Health Services Board, 2000).

4.9.1.2 Organisational Review

The first steps towards a change in the organisational structure of Royal Perth Hospital occurred in January 1994 when 43 medical consultants spent 3 days at a residential workshop to discuss the issue. At that meeting, it was agreed by the attendees to pursue a programme of organisational change (Stewart-Wynn & Marshall, 1996).

The Royal Perth Executive of the time made a conscious effort to ensure the change management process would be one that would be consultative and participative of all hospital staff.

In the first issue of a Clinical Directions Bulletin, the Chief Executive Officer wrote:

> "While RPH is not unique, it will take a different path from other
> hospitals which, apparently for reasons of speed and efficiency, have
> used the 'CEO directive' approach. Instead, we have chosen to take
> the somewhat longer route to allow consultation with staff and to tap
> into the 'know-how' of those at the 'coalface'".

<div align="right">Royal Perth Hospital (1994a:1)</div>

With the Hospital Board's endorsement, the Clinical Directions Project was commenced in March 1994. The project's principle objectives were to introduce organisational change through open consultation and with doctors at the forefront (Stewart-Wynn & Marshall, 1996).

Twelve Directions Review Groups comprising representatives of various services were quickly formed (Royal Perth Hospital, 1994b). Their brief was to make recommendations on future services and to develop an organisational structure that would be appropriate for the next 5 to 10 years. That structure would need to promote efficiency and effectiveness in the management of their particular clinical service. The groups were designed to transcend the existing departmental boundaries and to take into consideration all aspects of service delivery (Royal Perth Hospital, 1994a; Royal Perth Hospital, 1994b).

The review groups were given 6 months to produce a report of practical recommendations on service delivery and organisational change that would be implemented within 12 months.

A series of final recommendations were subsequently submitted to the Board of Management in early 1995. It was proposed that the hospital would be restructured with the creation of 11 Clinical Divisions (Directorates). The proposed directorates were: Cancer, Cardiovascular, Clinical Neurosciences, Critical Care, Elective Orthopaedics, Gastrointestinal, Imaging, Laboratories, Medical Specialties, Rehabilitation and Surgical Specialties. Their constituents are shown on the following organisational chart (Royal Perth Hospital, 1994d).

Hospital Board

Chief Executive Officer

Chairman of Clinical Directors | Director of Nursing Services | Director of Clinical Services | Director of Finance & IT | Director of Admin Services

Cancer	Cardiovascular	Clinical Neurosciences	Critical Care	Elective Orthopaedics	Gastrointestinal	Imaging	Laboratories	Medical Specialties	Rehabilitation	Surgical Specialties
Breast	Cardiology	Neurology	ICU	Elective Orthopaedics	Gastroenterology	Radiology	Biochemistry	Internal Medicine	Acquired Brain Injury	ENT
Head & Neck	Cardiothoracic Surgery	Neurosurgery	Trauma	RPRH Theatres	Colorectal	Nuclear Medicine	Haematology	Dermatology	Neurological Rehabilitation	Opthalmology
Urological	Vascular Surgery	Psychiatry	Emergency Department	Back Pain Management	Stomal Therapy		Immunology	Clinical Immunology	Spinal Trauma	Urology
Lung	Respiratory Medicine (part)	Neuroradiology	Emergency Orthopaedics		Upper GI		Microbiology	Communicable Diseases	Amputees	Anaesthesia
Melanoma & Skin		Epilepsy	Burns		Hepato-pancreato-biliary		Neuropathology	Endocrinology & Diabetes	Orthogeriatrics	Plastics
Haematological Malignancies		Stroke Unit			General Surgery (part)		Pathology	Geriatrics	Burns Rehabilitation	Medical Physics
Medical Oncology		Neuropathology						Respiratory Medicine (part)	Rheumatology	
Palliative Care								Renal Medicine	Rehabilitative Urology	
Radiation Oncology								Acute Rheumatology	Orthotics	
General Surgical									Rehabilitation Engineering	
Surgical Specialties (part)										

Figure 4.5   Directorate Structure - Royal Perth Hospital
Adapted from: Royal Perth Hospital (1994d:4)

At this stage of the planning process, the alignment of the Allied Health services was still to be determined (Royal Perth Hospital, 1994d).

A Clinical Director would lead each directorate. Their responsibilities would include:

- Developing the direction and priorities of the services offered by their directorate within the hospital's strategic framework.
- Contributing to hospital policy and decision-making.
- Establishing the means to respond rapidly to change and external pressures.
- Developing and implementing a business plan for their directorate.
- Ensuring that teaching and research are maintained and further developed.

Royal Perth Hospital (1994d)

A Business Manager and Nurse Manager would support each Clinical Director. Although these two positions would still maintain their professional accountability to

the Director of Finance & Information Technology and the Director of Nursing Services respectively, the directorate would be free to develop its own internal working relationships (Royal Perth Hospital, 1994d).

It was suggested that the new Clinical Directors would report to a Director of Clinical Services, whose role would be one of support and policy advice. A Chairman would be elected from among the 11 Clinical Directors to represent the directorates on the Hospital Board of Management. The Chairman would have direct access to the Chief Executive Officer and be responsible for maintaining regular communication with the other Clinical Directors (Royal Perth Hospital, 1994d).

The posts of Director of Nursing Services, Director of Finance & Information and Director of Corporate Services would be retained, but their roles would be redefined. Under the new structure, the makeup of the Medical Advisory Committee would be changed to include each of the Clinical Directors, the Director of Clinical Services, the Director of Nursing Services and Chairman of Academic Group (Royal Perth Hospital, 1994d).

In March 1995, the Hospital Board of Management approved restructuring on the condition that it was initially implemented for a only a 12-month period.

In an open letter to the staff, the Chairman of the Board of Management wrote:

> "The changes in organisational structure very much reflect the modern corporate management practice – less centralisation and greater devolution of responsibility to the functional units of the organisation. The new directorate structure is intended to enhance the clinical services by providing greater integration and hence improving quality and cost effectiveness.
>
> The exercise is essentially Royal Perth Hospital's response to the ongoing call for greater cost effectiveness, enhanced quality and improved management – in short, more value for the health dollar."

(Royal Perth Hospital, 1995a:1)

Being the early stages of directorate development, the devolution of budgets was proving a difficult task for the hospital's finance department. It was anticipated that the directorates would be closely involved with developing the hospital's submissions for the coming financial year (Royal Perth Hospital, 1995b).

At this time, it was generally accepted that the role of Departmental Heads was still in transition. Prior to the introduction of directorates, their role was largely representative. With the devolution of budgets and decision-making to directorates, Departmental Heads were able to have a greater input into matters that affected their departments. Many believed their role was primarily one of providing professional leadership, teaching and research. Approximately half of the Clinical Directors were also Departmental Heads, however, none saw a conflict with this dual role. They were able to easily distinguish the managerial role of their Directorship from their clinical role as a Departmental Head (Royal Perth Hospital, 1995b).

Nine months after the directorates were implemented an externally commissioned survey was conducted to gauge staff opinion of the new directorate structure. The overall assessment was that the…

> "… survey showed a fairly positive response to change,
> especially so early in a new system"

(Royal Perth Hospital, 1996a)

The positive feedback was encouraging for the hospital. The final recommendations for the new directorate structure soon followed. They were:

- The Directorate Management Group should be a tri-partite structure and consist of a Clinical Director, Nurse Manager and Business Manager.
- Appointments should be for a 5-year period with no automatic redeployment if a contract is not renewed.

- The Hospital Executive, Clinical Directors' Forum and Clinical Policies Committee should ensure that key information, decisions and instructions are communicated to the appropriate stakeholders.

- A Communication Audit should be performed to determine whether information is suitable, reliable, credible, relevant, timely, clear and not duplicated.

- The hospital pursues the development of electronic communication systems.

- An annual hospital-wide staff climate survey is performed.

- Research and teaching are more prominently promoted.

- The role of Clinical Director as co-ordinator of clinical services complements and not replaces the role of the Departmental Head.

- The Departmental Head's role is to represent specialty interests within the strategic planning process.

- A Strategic Planning and Review Committee should be developed to pro-actively plan service delivery, teaching and research, policies and future direction.

- Larger departments should increase regionalisation of their activities in liaison with other hospitals.

- Multicultural and translated information should be made available upon discharge and at outpatient clinics.

- Greater involvement of the clinical directorates in important strategic decisions should be encouraged.

(Royal Perth Hospital, 1996b)

4.9.1.3 Outcome of Restructure

As a testament to the detailed planning and inclusiveness of the change management process, the clinical directorate structure at Royal Perth Hospital has continued in its original form for more than a decade since its original inception. It still existed in the same form at the time of data collection.

4.9.2   Sir Charles Gairdner Hospital

4.9.2.1   Overview

Sir Charles Gairdner Hospital is an Australian Council on Healthcare Services (ACHS) accredited 606 bed tertiary hospital located on a 28 hectare medical campus 5 km west of the Perth CDB (Sir Charles Gairdner Hospital, 2006).

Being the most modern teaching hospital in Western Australia, Sir Charles Gairdner Hospital has a relatively short history. Built in 1958, the hospital sits on a tract of land made available from the University of Western Australia. In its beginnings, the hospital only dealt with tuberculosis patients.   However, as the incidence of tuberculosis began to decline through 1959 and the early 1960s, the hospital's role began to broaden with the admission of general medical and surgical cases. In 1963, in recognition of this changing role, the hospital was renamed in honour of the then Governor of Western Australia, Sir Charles Gairdner (Sir Charles Gairdner Hospital, 1994; Sir Charles Gairdner Hospital, 2006).

The hospital continued to grow with extensions being built throughout the 1960s, 70s and 80s. It now operates across a further two campuses: Osborne Park and the South Perth Community Hospital (Department of Health, 2006). The main hospital is a 24-hour acute care public teaching hospital. With the exception of major burns, paediatrics, obstetrics and gynaecology, Sir Charles Gairdner Hospital offers a comprehensive suite of major tertiary services (Sir Charles Gairdner Hospital, 2006). The hospital is also the state referral centre for a number of specialist and super-specialist services including elective neurosurgery, complex radiotherapy, exotic infections, adult liver transplantation and tuberculosis (University of Western Australia, 2006).

The hospital's catchment area extends along the coast north of the Swan River to Joondalup and to the east it is bounded by the Shire of Swan and the Cities of Stirling and Perth (Health Department of WA, 1989).

The Nedlands campus has on average 518 in-patient beds. An additional 34 in-patient beds are accessible through the Osborne Park campus and 15 care awaiting

placement beds are available at the South Perth Campus (Sir Charles Gairdner Hospital, 2006).

Sir Charles Gairdner Hospital has approximately 57,000 admissions and 90,000 outpatient attendances each year. Its Emergency Department has more than 35,000 presentations per annum. The hospital has approximately 2,600 full-time equivalent positions (Metropolitan Health Services Board, 2000).

4.9.2.2 Organisational Review

Recognising the need to maximise the hospital's efficiency and effectiveness, the hospital's Board of Management embarked upon a hospital-wide review in mid 1993.

The Chief Executive Officer recommended that external consultants be used to assist in the review and as such, the process was lead by the international consultancy firm Booz-Allen & Hamilton (Sir Charles Gairdner Hospital, 1994).

At the commencement of the review, the organisational structure of Sir Charles Gairdner Hospital was typical of the time, with services aligned according to medical, surgical, nursing and corporate divisions.

Following the completion of a diagnostic review in September 1993, the hospital moved quickly to develop options for organisational change (Sir Charles Gairdner Hospital, 1994; Peachment, 1997).

A number of Task Force Groups were established and in consultation with Booz-Allen & Hamilton, the Hospital Executive set a series of parameters regarding the organisational restructure. They included:

- No more than 6 clinical directorates should be developed.
- Each clinical directorate should consist of a minimum of 70 beds in order to achieve economies of scale.
- Some central services such as Allied Health should be departmentally maintained and costed rather than allocated to directorates.

Joyce (1994)

The result was the formation of 5 clinical directorates, termed Clinical Service Units (CSUs). They were Gastro and Renal Services, Heart and Lung Services, Neuroscience Services, Acute Musculoskeletal and Rehabilitation Services and Cancer Services (Joyce, 1994).

In determining the size and structure of a directorate, the review taskforces gave consideration to the geographical location of patients and the services they utilised. For example, to maximise the utilisation and sharing of staff, propositions were made to align specific wards with directorates (Joyce, 1994).

It was decided that a single clinical directorate trial would be implemented prior to committing to an entire organisational restructure. The area chosen to trial was gastroenterology and renal medicine (Joyce, 1994; Sir Charles Gairdner Hospital, 1994).

A Gastro-Renal Services Unit was established in early 1994 under the Co-Directorship of a Medical Practitioner and a Nurse. Under this model both Co-Directors had equal status and responsibility (Sir Charles Gairdner Hospital, 1996). The clinical directorate was supported by a Financial Officer to assist with budget control and an Executive Secretary (Joyce, 1994).

The Co-Director model that was implemented for Gastro-Renal Services received considerable criticism from the medical staff. For that reason, a second trial directorate for Heart and Lung Services was soon established to operate under a single Director model, where that Director was a Medical Practitioner (Joyce, 1994). The management structure for this directorate was subsequently changed to a Co-Director model prior to the implementation of the remaining directorates.

The recommended 5-directorate structure was completed in April 1996. However, an additional directorate, the Central Services Directorate was established by the end of the year (Sir Charles Gairdner Hospital, 1996).

By the end of 1996, the organisational restructuring of Sir Charles Gairdner Hospital was complete. The structure and reporting responsibilities are shown below:

Board of Management

Chief Executive Officer

Executive Director Medical Services — Executive Director Nursing Services

Cancer CSU	Acute Musculoskeletal CSU	Central Services CSU	Gastrorenal CSU	Heart & Lung CSU	Neurosciences CSU	Director Finance & Corporate	Director Facilities Mgt	Director Human Resources
Clinical Haematology	Clinical Immunology	Day Surgery	Gastroenterology	Cardiovascular Medicine	Endocrinology	Financial Services	Engineering & Building	HRIS Project
General Surgery	Dermatology	Operating Theatres	General Surgery	Cardiothoracic Surgery	ENT	Information Services	Gardens & Grounds	Education & Development
Medical Oncology	Geriatric Services	Anaesthetics	Renal Medicine	Respiratory Medicine	Neurology		Healthcare Foods	Employee Relations
Radiation Oncology	General Medicine	CSSD	Urology	Pulmonary Physiology	Neurosurgery		Site Support	Human Resource Operations
	Orthopaedics	TSSU	Vascular Surgery		Opthalmology		Supply	
	Plastic Surgery	Radiology			Pain Management			
	Rheumatology	Nuclear Medicine						
		Medical Technology & Physics						
		Outpatient Services						
		Psychiatric Services						
		ICU						
		Emergency Department						

Figure 4.6   Directorate Structure - Sir Charles Gairdner Hospital
Source: Sir Charles Gairdner Hospital (1996)

4.9.2.3   Outcome of Restructure

The organisation structure that was implemented over the period 1994 to 1996 still existed in 2003 at the conclusion of the data collection period of this study.

4.9.3　Fremantle Hospital

4.9.3.1　Overview

Fremantle Hospital is an Australian Council on Healthcare Services (ACHS) accredited 450 bed tertiary hospital located 20 km southwest of the Perth CDB in the port city of Fremantle. First established in 1887, it has operated across three campuses: Fremantle Hospital, Woodside Maternity Hospital and the Rottnest Island Nursing Post. The main hospital is a 24-hour acute care public teaching hospital. It offers most major tertiary services and is the state referral centre for Diving and Hyperbaric Medicine.

The hospital's region is geographically large with the number of people in the catchment area totalling approximately 330,000 (Metropolitan Health Services Board, 1999).

The South Terrace campus has on average 384 in-patient beds. An additional 66 psychiatric beds are accessible through the adjacent Alma Street Clinic campus. At the time of data collection, 40 beds were available on the Woodside Maternity Hospital campus (Fremantle Hospital and Health Service, 2006). The Woodside campus has since closed and in December 2004 was replaced by the 66 bed Kaleeya Hospital campus (King Edward Memorial Hospital for Women, 2008).

Fremantle Hospital is a busy hospital for its size having approximately 40,000 admissions and 70,000 outpatient attendances each year. Despite it being the smallest of Perth's three public teaching hospitals, it's Trauma and Emergency Centre still sees more than 40,000 people per annum pass through its doors. The hospital has approximately 2,100 full time equivalent positions (Metropolitan Health Services Board, 2000).

4.9.3.2　Organisational Review

An organisational structure that would involve the devolution of management responsibilities to clinicians was first considered for Fremantle Hospital in 1995. In a

discussion paper entitled 'An Introduction to Clinicians in Management' the Chief Executive Officer of the time wrote:

> "The Board and Executive is under constant and increasing pressure to reduce operational costs in relative terms, while at the same time respond to demands to provide new and expanded services.

> If Fremantle Hospital is to cope with these challenges on a long term basis, it is imperative that our focus is on the needs of our patients and that our doctors, nurses and allied health professionals share in the management of our diminishing resources."

(Fremantle Hospital, 1995:1)

At that time, the organisational structure of Fremantle Hospital was typical of the traditional professional hierarchical form. At the apex of the structure was the Hospital's governing body - the Hospital Board.

The next level of the hospital's organisational structure was the Executive Management Team, which was lead by the hospital's Chief Executive Officer. The Executive consisted of four Directors. They were Directors of Clinical Service, Nursing Services, Corporate Services and Administrative & Support Services. Each Director was responsible for specific departments or services that fell under their particular jurisdiction. Either a Departmental Head or Middle Manager then managed each department or service.

In response to an environment of health budget constraints, casemix funding, internal pressures on beds and demands of new technology both the Board and the Executive believed that a change to the hospital's management structure had to occur. An outside consulting group was engaged to review the existing organisational structure and facilitate discussion on possible structural changes.

The early stages of the analysis encouraged discussion on the principles and fundamentals of a devolved management structure rather than focus on the specific details of the proposed organisational change (Fremantle Hospital, 1995).

Initially it was proposed that the clinical directorate management team would consist of a Clinical Director as Chairperson, a Nurse Manager, a Business Manager and a General Practitioner representative.

A Working Party was formed to look at possible structures. It subsequently recommended a four-directorate model consisting of psychiatric, medical, surgical and diagnostic services.

A Clinical Directorates Implementation Team consisting of a Clinical Development Director, a Nurse Project Officer and a Business Project Officer was formed to progress the change process. The team closely examined issues such as budgets staffing, clinical relationships, strategic imperatives, directorate size and complexity, reporting relationships, critical staff recruitment, implementation costs, communication and management information and General Practitioner involvement (Clinical Directorates Implementation Team, 1996).

The clinical directorates were developed to contain natural groupings of medical or surgical specialties so that the disciplines within the directorate shared a common patient focus. For example, although Cardiology would normally fall into a Medical Service Directorate, it was placed within the Surgical Services Directorate as a companion specialty to Cardiothoracic Surgery (Clinical Directorates Implementation Team, 1996).

The clinical directorates were to be structured in such a way as to provide the flexibility to meet the challenges of a changing health environment. Regular planning was expected to ensure that the directorates' structure would continue to match the hospital's service developments and initiatives. It was also anticipated that service groups could possibly evolve within the clinical directorates until eventually new service-specific directorates would be formed (Clinical Directorates Implementation Team, 1996).

The structuring of the clinical directorates took into account factors such as the number of departments within each clinical grouping, the number of allocated beds, staff numbers and operational budgets. Staffing, bed allocations and recurrent budgets for each clinical directorate were based upon historical data. This data was then adjusted for forthcoming service developments that the hospital had planned (Clinical Directorates Implementation Team, 1996).

The recurrent budget of each clinical directorate comprised the historical operational budgets of each department that sat within the directorate. This included the budgets associated with clinical, nursing, administration and support services. To make each clinical directorate viable, it was anticipated that the recurrent budget should be in the range of $10-15 million. It was planned that the Clinical Directors would have discretionary control over these budgets and that a framework for the development of budgetary, financial and general business rules would be established over time (Clinical Directorates Implementation Team, 1996).

Staff who reported centrally such as Ward Clerks, Patient Care Assistants, Orderlies and Cleaners together with the allied health staff were allocated to each clinical directorate during the implementation period (Clinical Directorates Implementation Team, 1996).

It was believed that a key requirement for the successful implementation of the clinical directorate model was that the Clinical Directors would be practicing medical clinicians who already had a leadership role within the hospital. The Nurse Managers and Business Managers would not necessarily come from existing personnel. However, some internal recruiting did occur due to the strong links between the new and existing positions (Clinical Directorates Implementation Team, 1996).

In determining the optimal number of clinical directorates, it was believed by the implementation team that a limited number of directorates would minimise information management and communication barriers. It was felt that a complex organisational structure with many clinical directorates would only promote deficiencies in management information (Clinical Directorates Implementation Team, 1996).

In initial schemas, it was proposed that General Practitioners should participate as members of the directorate management team. Refinement of the directorate structure saw General Practitioners removed from the management structure with the suggestion that the clinical directorate management teams should provide a forum for regular formal General Practitioner input (Clinical Directorates Implementation Team, 1996).

The Hospital Board endorsed the following structure in October 1996:
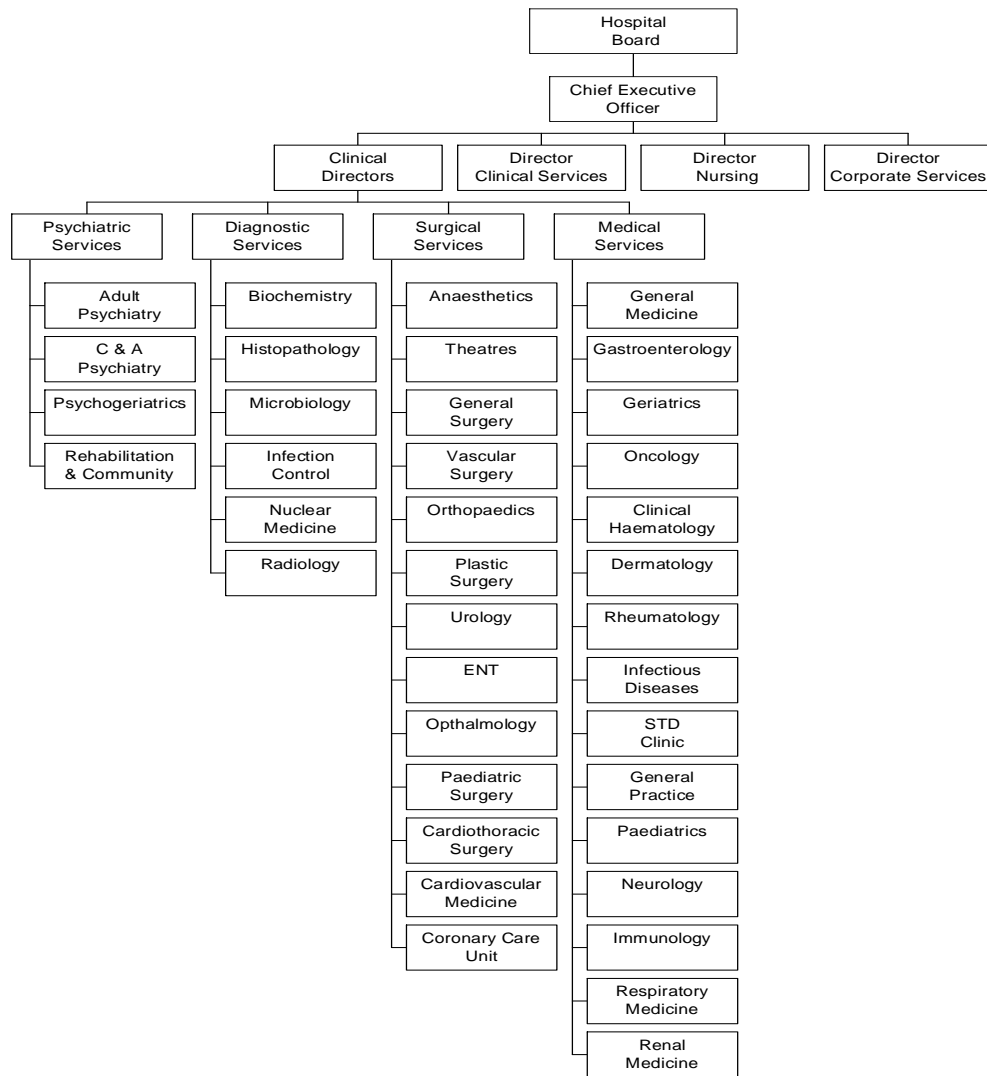
Figure 4.7   Directorate Structure - Fremantle Hospital
Adapted from: Fremantle Hospital (1996:1)

A few months later, the roles and responsibilities of the hospital's pre-clinical directorate Executive were modified and clarified. The previous hospital Executive was reduced from four to three, their titles were changed and their responsibilities realigned. Their new titles were Executive Director – Clinical Services, Executive Director – Nursing and Patient Support Services and Executive Director – Corporate Services.

4.9.3.3 Outcome of Restructure

The clinical directorates operated in this form until 2001 when a change in the reporting relationship between the Executive Clinical Directors and the Clinical Directors was introduced. This change prompted the resignation of three of the four Clinical Directors. In effect, the hospital's organisational structure reverted to a hybrid directorate structure whereby the management teams continued to exist, yet report to a single Director of Medical Services. The structure established by the review was no longer in place at the time of data collection.

4.10 Chapter Summary

The Australian healthcare system is a universal healthcare system that involves a mix of both public and private sectors. Both Federal and State governments are involved in the provision of healthcare in Australia. The Federal government is primarily responsible for health policy whilst the State governments are principally responsible for the delivery and management of public health services.

Healthcare funding in Australia is sourced from Federal, State and Local government funds as well as individuals, non-government organisations and health insurance funds. Constraints in State funding for pubic sector hospitals over the past decade and a half has put considerable pressure on the public hospital system. In Western Australia, organisational change has been used as a tool to combat the increasing demands for cost constraint and improved efficiency. Such change has been by way of the devolution of responsibility and the introduction of doctors to management.

Structural changes in Western Australia's public teaching hospitals have supported the devolution of management. The introduction of clinical directorates has resulted in significant changes to the way in which the hospitals are now managed.

Each of the three hospitals that participated in this study introduced clinical directorate structures in the mid 1990s. Whilst Royal Perth Hospital and Fremantle Hospitals introduced hierarchical forms of clinical directorates, whereby a doctor takes ultimate responsibility for its management, Sir Charles Gairdner Hospital introduced a co-director model, which saw a doctor and a nurse jointly responsible for the directorate's functioning. Although the structure and nomenclature adopted by each hospital varies, the concept of devolving of management to doctors is common to all.

Chapter 5 Findings

5.1   Introduction

This chapter describes the findings drawn from the analysis of 39 transcribed interviews. It seeks to express what the 39 respondents believe to be the dimensions of efficient and effective clinical directorship.

The findings are illustrated with italicised quotes from the interviews and summarised using diagrams. The approach used to present the findings is one that draws upon a descriptive quote to summarise the finding and then uses a series of supporting quotes to highlight its rigour. So that they may be presented together, three points and a forward slash (…/) separate the supporting quotes. The supporting quotes may sometimes appear incomplete. However, this approach was intentional as it facilitates the reading of the quote without change to its meaning. To this end, incomplete statements that do not have clear meaning, automatic speech patterns and inappropriate adjectives have been deleted.

Throughout the findings, the terms clinical directorate or directorate have been used in place of the terms Division (Royal Perth Hospital) or Clinical Service Unit (Sir Charles Gairdner Hospital). The purpose of this was two-fold; the first was to create a uniform nomenclature across all findings; the second was to ensure that the origin of the quote remained anonymous. Position titles and references to organisations have been replaced by generic terms to again maintain anonymity. The titles Nurse Co-ordinator (Royal Perth Hospital), Nursing Co-Director (Sir Charles Gairdner Hospital) and Nursing Director (Fremantle Hospital) have been termed Nurse Manager. The title Business Manager replaces Finance and Budget Officer (Sir Charles Gairdner Hospital).

Simple verbs were added to quotes for grammatical purposes. They are identified by parentheses. Care was taken to ensure that the insertion these words did not alter the meaning of the statement.

5.2   The Respondents

Thirty-nine interviews were conducted for this research. The interviews were divided equally between each of the three major pubic teaching hospitals resulting in thirteen interviews being conducted at each.

The interviews were conducted with 3 Chief Executives, 13 Clinical Directors, 11 Nurse Managers, 9 Business Managers and 2 Department Heads.

	Fremantle Hospital	Royal Perth Hospital	Sir Charles Gairdner Hospital
Chief Executive	1	1	1
Clinical Director	3	5	5
Nurse Manager	4	4	4
Business Manager	3	3	3
Department Head	2	0	0
Total	**13**	**13**	**13**

Table 5.1   Respondents According to Hospital and Role

Of the respondents, 26 (66.6%) were male and 12 (33.3%) were female. All 3 (100%) Chief Executives were male, all 13 (100%) Clinical Directors were male, 10 (83.3%) Nurse Managers were female and 2 (16.6%) were male, 6 (66.6%) Business Managers were male and 3 (3.3%) were female, both Department Heads (100%) were male.

The median age group of the respondents was 41-50 years old. Eleven respondents (28.2%) were the inaugural holder of the position they occupied at the time of interview. Twenty-two (56.4%) of the respondents had more than 3 years experience in the positions they occupied at the time of interview. Sixteen (41.0%) possessed tertiary qualifications in management or a related field at the time of interview and thirty-four (87.2%) had previously had some form of management training.

5.3   The Dimensions of Efficient & Effective Clinical Directorship

The perceived components of efficient and effective clinical directorship are grouped under three super-categories (dimensions).   The dimensions are: knowledge and skills that are contextually specific to the health domain, business skills that are learned and personal attributes that are brought to the role.

Dimensions of
Efficient and Effective Clinical Directorship

Domain Knowledge & Skills   **Personal Attributes**

Business Skills
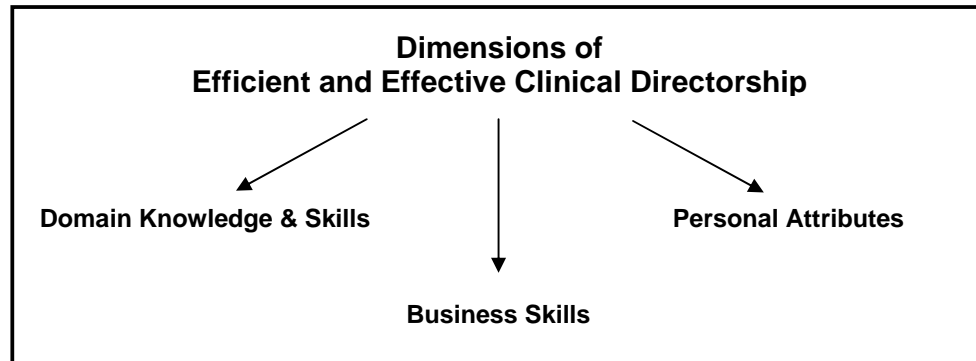
Figure 5.1   The Dimensions of Efficient and Effective Clinical Directorship

5.4   Domain Knowledge and Skills

The public health domain in which Clinical Directors and their directorates function strongly influences their success.   Respondents identified certain knowledge that doctors bring to the role and a range of skills that are contextually specific to the health domain.   They include clinical experience, peer influence, political expertise and knowledge of the public health system.

DOMAIN KNOWLEDGE AND SKILLS

Clinical Experience   Knowledge of the
                                                       Health Environment

Peer Influence   Political Expertise
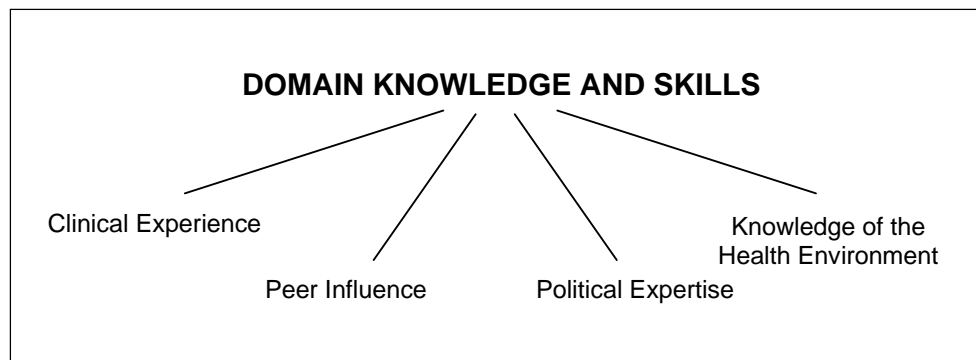
Figure 5.2   Domain Knowledge and Skills

5.4.1 Clinical Experience

To be successful, many respondents believed that a Clinical Director must be a current and well-experienced medical practitioner. As one, they are able to easily bring their clinical experience to the table in making management decisions. Such clinically-based decisions would be influenced by a focus on quality healthcare, the fundamentals of clinical governance and evidence-based medicine.
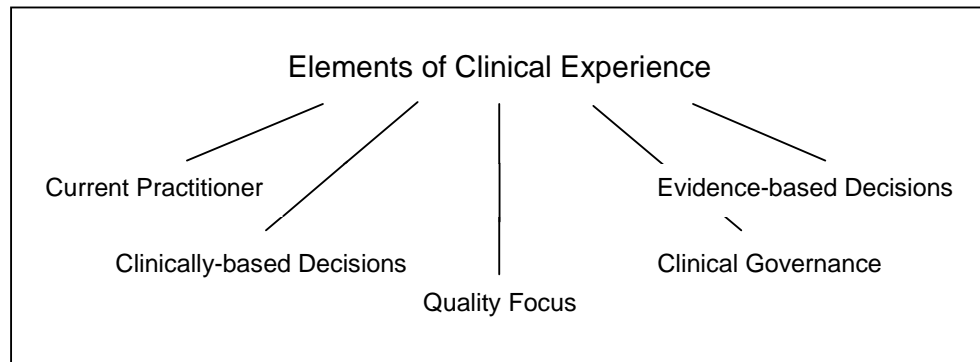
Figure 5.3   Elements of Clinical Experience

5.4.1.1 Current Practitioner

Many respondents believed that to be successful, a Clinical Director must be a currently practicing clinician. As suggested by one Business Manager:

I think being a practicing physician is absolutely essential. Not just having a wealth of experience, but a current practitioner.

Others felt similarly:

...// If they know that the person saying no to them is also a clinician, currently practicing in the same organisation, then they're much more likely to accept it as being a valid and rational decision...// it was a real boon to leadership - just being a practicing [clinician] in a particular field and having a vision about where things should be going and what things [were] right and what things were wrong...// You need to be physically working as a physician...// you're probably a better manager if you maintain some clinical focus...// they ideally have to be practicing clinicians...//

Relevant and significant clinical experience was also considered important:

…// They need to have knowledge about the area in which they're working…// they need a good clinical background and understanding of the area they're working in…// you have to have quite a bit of clinical experience…// I don't think you can do it without clinical experience and I think you need a minimum of five to ten years…// one of the important things is their clinical knowledge and their clinical expertise…//

5.4.1.2   Clinically-based Decisions

A number of respondents believed that the clinical input a Clinical Director brings to management decisions is an important contributor to successful clinical directorship. As put by one Clinical Director:

Clinicians are the people who understand what the clinical process actually is and how they can change it.

Others felt similarly:

…// I think what they are bringing to the role would be their medical input into the decision-making process…// they have an understanding of how medicine works, where a non-physician can't…// one of the problems in the past with administration was that there was someone making the decision who has never looked after a patient and obviously doesn't realise quite the impact of what that decision might mean at ward level…// they have an understanding of the medical situations better and they have that focus on the medical effects and all of those issues that are not appreciated by … the administrative side…// people can attempt to present cases as important (where they're actually not) and sometimes that's very obvious to someone with clinical knowledge … people without clinical knowledge would have to accept advice on it and they're more easily misled…// clinical staff understand the concept of clinical excellence [and] high quality healthcare services at a level where they're working with patients. A lot of corporate directors barely see a patient from day to day.

In contrast to this, a number of respondents believed that because of their clinical background, Clinical Directors often find it difficult to separate their clinical and managerial responsibilities. One Business Manager suggested:

… one of the biggest challenges is that because most professional Heads have a clinical role, then it's difficult to distinguish the clinical role from the managerial role.

Others who were not Clinical Directors supported this notion:

…// the fact that they are doctors does hinder them, because at the end of the day…they're always going to have their patients' best interest in mind and unfortunately, that's not always in the best interest of the directorate…// Well largely they just err on the side of the patient's best interest and the fact that we're not truly accountable for our budgets…// they're too close to the front line…// They're patient focussed and they see a very narrow view…// because they think like doctors – that to an extent might hinder …// that's always going to be a conflict for them – trying to balance the financial management against a patient's best interest…//

A number of respondents believed that this dichotomy is as a consequence of the medical training process:

…// if you look at … physician training, its focussed on an individual relationship with the patient and its focussed on [a] clinical problem. It's not geared around seeing the picture this wide…// There's that issue of 'let's be pragmatic and solve the problem' … and don't worry about the consequences. I think to a large degree, [this] probably comes from their training…// I don't know if their educational background actually assists them…// Medical education in general is about 'whatever … the patient needs – the patient gets'…//

One Nurse Manager made the important point that this internal conflict is not necessarily a bad thing:

I don't think that a Clinical Director's goals are always in line with the organisational goals. Although they are involved and aware of what can be our restrictions, they still come from a base (of when it boils down to it) [that] they [are] a clinician and they will want to know why they can't do this for their patient. I actually don't want us to lose that because that's our conscience.

5.4.1.3   Quality Focus

Many respondents believed that a measure of a Clinical Director's success is the quality of patient care their directorate provides. When discussing efficiency, one Clinical Director reflected:

I think you would have two things on your mind. You'd have finance and [budget], but I would actually argue that more importantly, what you should have your mind on, is the quality of service you provide.

Others agreed:

…// I'd see a measure of a good Clinical Director is also their commitment to quality…// quality is certainly an important part of providing the service. You can't just look at how efficient you are…// Looking at the quality of work that's done in the directorate – that can be an effective measure of efficiency…// I think the whole issue of safety and quality and clinical governance is now a requirement…// I think you want to be developing high quality patient care…// you have to work out what your goals would be and patient care would certainly be in the top couple…//

Benchmarking is often used as a comparative measure of performance. A number of respondents believed that a good Clinical Director is one who uses such measures:

...// You'd be looking at benchmarking against similar type hospitals and their output and their use of resources...// we have also made comparisons across a number of indicators with other like organisations across Australia as part of the benchmarking exercise called 'a round table'...// We participate in ... the health round table, which is where you benchmark what you're doing...// There is benchmarking against other hospitals...// This hospital, for example, does benchmark itself against other institutions around the country...//

Achieving accreditation through the Australian Council of Health Services (ACHS) was also considered a good indicator of successful clinical directorship:

...// the Clinical Director takes the [responsibility] (I suppose the buck stops with him) [of] things like recommendations from the ACHS...// we've been through the accreditation process and we've been able to regularly achieve those goals...// You have things coming up like ACHS accreditation. Has the directorate done all the bits it was suppose to do for accreditation?...//

5.4.1.4   Clinical Governance

Clinical Governance, as defined by Scally and Donaldson (1998:61), is:

"A framework through which organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."

This definition was clearly supported by one Chief Executive:

… by clinical governance I mean a gamut of professional issues associated with [the] provision of clinical services that include appropriate safety and quality guidelines. Appropriate processes for credentialing staff and making sure that staff are skilled in the procedures that they are doing and [that] there's a mechanism by which that's reviewed from time to time.

Many respondents believed that focusing on clinical as well as business outcomes is an important dimension of successful clinical directorship. As pointed out by one Chief Executive:

If I was looking at how someone is performing, I'd want to know what do they have in place. Do they have an appropriate clinical governance system?

Others echoed this thought:

…// in essence, I'm looking for someone who is responsible for what I'd regard as good clinical governance…// clinical needs and clinical governance should be a major area…// I think the whole issue of safety and quality and clinical governance is now a requirement…// its about promoting a message about the importance of clinical governance…// we can be assured that we actually have a proper clinical governance in the hospital…//

5.4.1.5   Evidence-based Decisions

Making decisions on service development that are based upon the latest clinical evidence was considered by many respondents to be an important component in successful clinical directorship. As suggested by one Business Manager:

I think the ideal would be for everyone to operate on evidence based practice – ideally to a gold standard.… Nothing gets implemented unless there's … solid evidence.

This was strongly supported by one of the Chief Executives:

What I'm looking for in a Clinical Director is an interpretation of the importance of evidence-based medicine - that we don't necessarily do things because we've always done them. I'm surrounded by people who have minds to say that if the evidence shows that we can produce these outcomes in terms of cure rates or quality adjusted life years or some other measure of outcome … then we should look at what we traditionally do and re-evaluate whether that produces the same output or not. I have, in terms of managerial sense, an ability to take the technical economic definition of efficiency and broaden it, but ultimately, it does come down to [the] question[s] of what's the outcome? Where's the evidence? What's the best combination to produce that output?

Others agreed:

…// I guess that what you [are] do[ing] within a directorate, as a Clinical Director, is measuring the use of the right evidence-based clinical work within a directorate…// issues of business are very much based on evidence and the ability to understand key principles to maintain health of an organisation and business unit…// I think that some Clinical Directors are in the positions, but [are] not really performing … and you can see that because evidence-based practice and the quality of work coming out of some areas [is] just not up to standard…//

It was suggested by one Nurse Manager that doctors find it difficult to translate their evidence-based clinical practice into a business context:

Recognising the value of acquiring evidence and support before making decisions – that's inherent to medical practice. Unfortunately, however, it's not automatic when those skills are applied to a business context.

5.4.2 Peer Influence

The data suggest that peer influence plays an important part in Clinical Director success. The clinical credibility of a Clinical Director, the way in which they performance manage their peers, the degree of respect their colleagues hold them in, the confidence with which they handle difficult peer issues and how assertive they are in enforcing unpalatable decisions upon their medical colleagues all contribute to a Clinical Director's efficiency and effectiveness.

Elements of Peer Influence

Peer Management

Credibility & Respect

Resolve
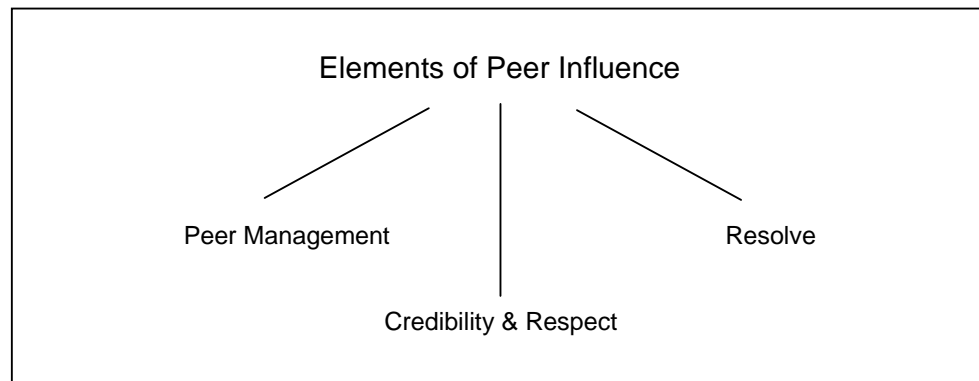
Figure 5.4   Elements of Peer Influence

5.4.2.1 Peer Management

Managing peers was considered by many respondents to be one of the most difficult tasks of clinical directorship. As one Clinical Director commented:

It has been likened to herding cats.

Others agreed:

...// The most difficult thing to manage in a hospital is probably your clinicians...// I think one of the obstacles that makes [a] clinical leader's job difficult, is their colleagues...// I think that sometimes their own colleagues don't help them either...// the biggest obstacle is their ability to be able to actually manage their peers...// I don't think it's easy - doctors managing other doctors...//

But why are their medical colleagues so difficult to manage? One Clinical Director suggested the reason was:

… you're dealing with very intelligent people who are probably working very hard under a significant amount of pressure who probably have a natural dislike of authority and control and probably hate bureaucrats.

Others felt similarly:

…// some of the clinicians can be very difficult to deal with. I think that's just the nature of the people you have to deal with…// some of the hard lessons for Clinical Directors [have] been in relation to dealing with difficult personalities and managing performance…// there are some very strong personalities around who can make life very difficult for you…//

As a consequence, many Clinical Directors find it difficult to performance manage their peers:

…// I've found that most doctors find it difficult to deal with their peers - whether it be from a performance management issue, whether it be from a resource issue…// There seems to be a general view amongst physicians and clinicians that the process of performance management is not that important…// when you performance manage doctors and assess them, you're doing it against criteria that don't involve their general clinical skills. It gets very hard. It is very difficult. Medical staff are very powerful. You run into problems trying to discipline them or curtail them…//

This often results in Clinical Directors being caught in, what may be considered, a no-win situation. As one Business Manager suggested:

…they needed to be seen on the one hand, from the hospital management [perspective], to be pulling their peers into line and on the other side, the peers were hoping that they would be able to get change to their benefit and I guess they were sort of caught in the middle trying to do the right thing by everyone.

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Others agreed:

…// they do their job for only three years and then they have to go back and work with their colleagues – there's a reluctance to performance manage because they have to do that…// when they don't deliver what their colleagues want, I think after a while their colleagues start to question where their loyalty or focus lies…//

Peers resorting to devious means often exacerbates the problem:

…// a lot of them will actually use blackmail to get their own way…// what I seem to see is that he who shouts the loudest gets the most…// people want to do things via the backdoor - often under threats of dire consequence if you don't do it…//

5.4.2.2   Credibility and Respect

Many of the respondents believed that the ability to influence peers is dependent upon the degree of credibility and respect that a Clinical Director commands from their medical colleagues. As one Business Manager observed:

If they're highly respected as a Physician, then their peers are much more likely to take on board their recommendations or assertions.

Others agreed:

…// it has to be someone who has status and has credibility with the other clinicians in their directorate, otherwise it won't work…// It has to be someone who has credibility with their colleagues, can provide the leadership required [and] can make decisions that would be acceptable to their colleagues…// They need to come with some sort of credibility or they won't get any co-operation at all…// There [are] issues of collegial respect - it's a persuasive tool when you want to get someone to do something…// I think that Clinical Directors have the credibility as clinicians, that they can get [other] clinicians to agree on how to do something…// Respect amongst their peers is what drove their ability to compel people to go along…//

In fact, one Chief Executive commented how the respect of peers was an attribute he looked for when appointing a Clinical Director:

I'm looking for someone who has the respect and ability to work with clinical peers to form part of a Medical Executive and advise me on medical issues in general and on medical issues in their particular area.

Some respondents believed that first and foremost, Clinical Directors needed to be experts in their own specialty. One Clinical Director believed that:

They need to be … a natural leader in their own clinical area of expertise.

Other respondents felt similarly:

…// I guess from a clinical perspective, being seen to be a leader in their field. I think if your standard of clinical practice is not highly regarded amongst your peers, it is very hard to try and convince them that they should alter their practice if they don't feel that yours is best…// I think that anything that was achieved by the former Clinical Director was achieved on the basis of their reputation as an exceptional clinician…//

It was also felt that collegial loyalty plays an important part in obtaining respect and the subsequent influence of peers:

…// They're very loyal and have a tendency to support each other for the sake of supporting each other in industry if you like. Doctors will generally come to the support of other doctors and will follow other doctors and this is more likely than non-medical administrators and that applies even more readily for the practicing clinician rather than the full-time medical administrator…// doctors need to be managed by doctors…// Without being a doctor who is a Director, you'll not get the other doctors coming along with you…//

A number of respondents believed that the length of time a Clinical Director has practiced medicine significantly contributes to the degree of peer respect and credibility they command. One Nurse Manager believed:

They will already have to be senior people. So anybody who has been in the hospital a long time, who people believe have a good understanding of patient care commitment [and a] good understanding of issues. People who are seen as fair, who behave in a way their colleagues respect.

Similarly, a lack of clinical experience could diminish the credibility of a Clinical Director among their peers. As one Business Manager suggested:

I think that doing [management] too soon in their clinical careers hinders their credibility. So they have their management training, but do they have the force of reputation to really back up their clinical path.

He continued:

I think you can always back up a very senior clinician with management people, but you can't confer that support among their peers.

Some respondents believed that peer respect is also derived from their standing among patients and within the wider community. In describing the respect for his Clinical Director, one Business Manager commented:

A lot of it I put down to him being who he is and the way he's regarded in the community.

Others were of similar mind:

…// if they have credibility with the public, they actually bring credibility to the health system…// he was recognised and respected within Western Australia, nationally and internationally…// Generally they're very articulate and well regarded within the community, within politics, as a person of substance…//

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5.4.2.3   Resolve

The confidence to effectively deal with their peers was considered by many respondents to be an important dimension of successful clinical directorship. As one Chief Executive commented:

They have to be prepared to stand up and actually contradict their colleagues at times. One of the problems, especially in the clinical field to a large degree, is of people's unwillingness to stand up and contradict their own colleagues, even though it is better for the system.

Others confirmed his comment:

...// [if] you haven't got a strong medical person as a leader, [they] are going to be walked all over by their colleagues saying this is what we want and if we don't get it, we're going to walk...// You have to make decisions and stick to those decisions. Let your colleagues know why those decisions have been made, whether they're popular or not, and try and actually pull people together into a team to see what the aim of the organisation is...//

A number of respondents believed that the difficulties in managing peers, stems from the political power that the medical fraternity commands:

...// they're very powerful, and in this organisation the medical staff wield huge amounts of power...// the power within the hospital is definitely vested with the medical staff...// If the medical staff are not happy with the way things are being run and they can't talk to a medical colleague in management about these problems, they tend to rock the boat...// they (individually and collectively) are more powerful and more empowered than a lot of other people employed at the hospital...//

Clinical knowledge helps a Clinical Director to make accurate assessments of the various clinical arguments that are put to them. As one Business Manager observed:

… the other thing they bring is the ability to see through a lot of rubbish that gets used about 'how people die without this certain whatever' and they are able to know that people 'won't die without that certain whatever' or that it might only impact upon one patient per year as opposed to something that might be cheaper and impacts on a lot more patients.

Similarly, one Clinical Director commented:

…as somebody close to the coalface, I think that I can pick what's important and what isn't important because there's no doubt that important things can be missed. I think it is equally true that people can attempt to present cases as important when they're actually not and sometimes that's very obvious to someone with clinical knowledge.

As with all managers, Clinical Directors are constantly placed in the position of having to make hard decisions. The political power of the medical fraternity within a hospital often makes decision-making even more difficult, as organisational goals are not necessarily the same as the goals of the doctors.

Being assertive with their peers was considered by many to be an important dimension of good clinical directorship. This quality, however, was considered by some respondents to be one in which Clinical Directors can be found wanting. As one Clinical Director observed:

[Clinical Directors] don't like conflict very much. When it comes to difficult issues with colleagues … [they] have a tendency, in my perception, to want to be liked and do all the nice things, but not take a fair but tough stand when it is necessary.

Others agreed:

…// I've found that most doctors find it very difficult to deal with their peers. Whether it be [a] performance management issue, whether it be … a resource issue, they generally try to please everyone and you can't…// I think they don't want to be seen to be the ones making those hard decisions…// They don't want to take sides or be seen to take sides…// Doctors don't like to deliver bad news all the time to patients and we aren't really that good at delivering bad news to our colleagues…//

Difficulties in dealing with their peers may stem from the conflicting philosophies that exist between patient responsibility and their role. As one Business Manager pointed out:

I think that sometimes they have a hard time equating the two parts of their job, saying no to other clinicians and at the same time striving for gold standards.

It may also be as a consequence of the way in which doctors tend to deal with each other. As some respondents pointed out:

…// being doctors, they'll always be very diplomatic. They always try and negotiate their way through with their colleagues so that neither person loses face. We've had some very difficult clinical debates between competing specialties and these have still not been resolved due to the fact that at the end of the day, clinicians will never make hard and fast decisions where someone is going to lose out…// They're able to ensure that the interests of their colleagues are protected and it may be that someone who is a bit more independent and who is a bit more answerable to the bottom line would be able to make some harder decisions…//

5.4.3 Political Expertise

The data also revealed that a successful Clinical Director must be a skilful politician. It was perceived that they must be politically astute and, given the politically charged environment in which they manage, have considerable negotiating skills.
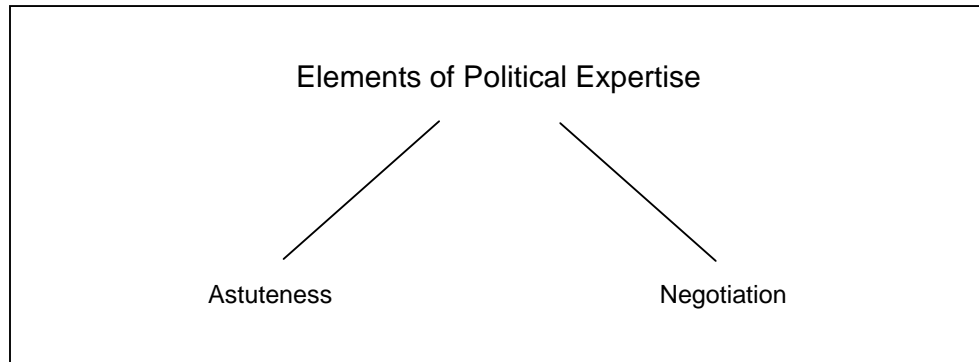
Figure 5.5   Elements of Political Expertise

5.4.3.1 Astuteness

It was perceived by the respondents that a Clinical Director must be politically astute in their dealings across the organisation. As one Nurse Manager pointed out:

… the other attribute they bring … to the table is politics. I believe [that] if we didn't have them sitting around the table in our model, we'd be missing [an] opportunity from a political level. They bring political astuteness and [an] ability to … tackle issues from a different level.

Others held a similar view:

…// they need to be politically astute and fairly flexible in their attitudes…// they know how to play the system, they know how to work the system…// a huge part of it is political really and putting the point of view of their directorate out there…// it's also a political role in that you have to be able to play the political game at a hospital executive level…// they develop an understanding of the politics that surrounds how to achieve and influence outcomes…//

5.4.3.2 Negotiation Skills

Part of a Clinical Director's political expertise requires them to possess well-developed negotiating skills. According to one Clinical Director, one must have:

… an ability to broker arrangements between various units in terms of competing demands, be it for theatre lists, clinic space, office space, financial resources, access to research grants, all those sorts of things.

Others held similar views:

…// you need to be able to negotiate and to lead people to areas where they don't necessarily want to go…// you have to have core skills in things such as negotiation…// they need to be able to negotiate with other heads of department within the directorate…// they have to have some very good negotiating skills…//

Negotiation skills are enhanced by an ability to facilitate discussion. As one Clinical Director noted:

I think good Clinical Directors are able to facilitate discussion, facilitate decision-making by doing that role.

Others concurred:

…// I can talk to my peers…and I can get agreement and move on from there…// I think we don't generally get to this stage without having developed a number of communication skills, which are invaluable in a job like this. Both communication and negotiating skills…//

The ability of Clinical Directors to negotiate with their peers was also considered by a number of respondents to be an important aspect of clinical directorship. As one Nurse Manager explained:

I think they need to be able to negotiate with other Heads of Department within the directorate and be respected by them as their leader - otherwise it is really quite problematic.

Others agreed:

…// They have to have some very good negotiating skills. I guess they are dealing with their peers and at times, we all think that the area we have is the best and that should have all the priority…// they always try and negotiate their way through with their colleagues…//

One Clinical Director described how the directorate structure contributes to the spirit of negotiation:

Because of the way that we're set up around the table, we have a combination of clinicians. We have Surgeons, we have Physicians, we have Intensivists, we have Radiologists and we have a broad range of actual medical expertise sitting around the table. It always I think, allows a rounder conversation and always brings different viewpoints to the situation because within that [group], there [are] competing needs for resources within this organisation. It's always quite well articulated with them sitting around the table.

5.4.4   Knowledge of the Health Environment

How well a Clinical Director knows the health environment in which they manage was considered by the respondents to be an important contributor to their success. The data suggest that a Clinical Director must not only be familiar with public sector processes and policies, but must also have a good working knowledge of their own organisation.
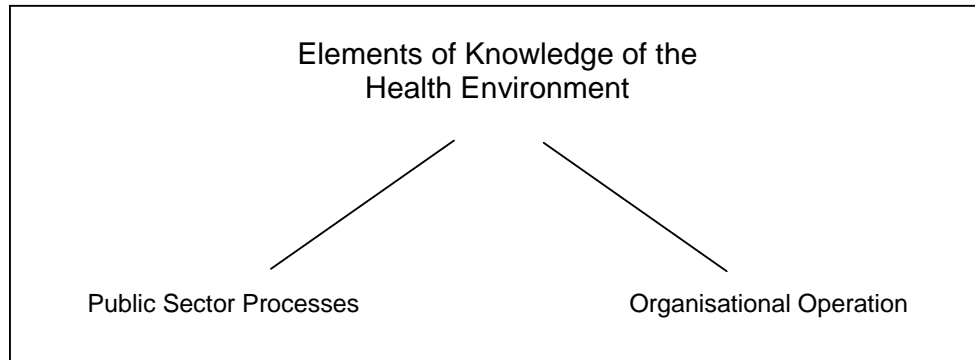
Figure 5.6   Elements of Knowledge of the Environment

5.4.4.1   Knowledge of Public Sector Processes and Polices

Many respondents considered that Clinical Directors must possess a good understanding of the public sector processes that exist within the health environment:

…// I think they have to have a fairly wide knowledge of health (if you're talking specifically about health), about the health industry, about its funding, its politics, about issues that are again not just clinical, but they actually have to know and understand that there are budgetary constraints…// They're all experienced people who have a pretty good understanding of a system as a whole and the pressures that are on that system…// We have to have a reasonable understanding of the health system as a whole…//

It followed that the bureaucratic environment in which Clinical Directors manage is one that must be well understood. As one Clinical Director pointed out:

One of the real issues for me and what I think is important of Clinical Directors, is that they need to have to come to understand the sort of broad

operations of the public sector system and how it influences the way we have to undertake the administrative role.

Other respondents felt similarly:

...// clinicians need to be aware of the public process and not work on the mentality of the private sector where you can just go out and 'buy that' or we can just 'hire that person' or just 'sack that person'. [The] requirement in the public sector standards [is] to do things financially accurate...// having a full spectrum of skills, particularly in the public service industry. To ... work within the confines of public sector policy...//

5.4.4.2 Operational Knowledge of the Organisation

Many respondents believed that a Clinical Director must also have an intimate knowledge of their organisation's workings. As one Nurse Manager suggested:

... there are some good medical clinicians out there who are good managers and good leaders, but a lot of them aren't because they don't really know how the organisation works. They really only see it from a medical perspective. They have no understanding of how the rest of the organisation works.

Others agreed:

...// they have to have knowledge of the systems of the hospital...// someone who knows what is going on is probably better than someone who has no idea...// You need to have an understanding of our hospital...//

A number of respondents believed that a long history of employment within the hospital assists with an in-depth understanding of its functions and operations. For example, one Nurse Manager believed that a good Clinical Director was one who:

...has been in the hospital a long time, who people believe [has] a good understanding of patient care commitment, [a] good understanding of issues...

Others held a similar view:

…// the bonuses are (a) he has worked here for an awfully a long time and (b) he wanted the position…// He has quite an extensive history. He was able to bring that corporate and cultural history with him to the position…//

They must also know the key players within the organisation and how to deal with them. One Nurse Manager felt they need to:

…have an understanding of … who are those people within the business who are key to the overall health and wellbeing of the organisation.

Others agreed:

…// They have to be able to network with other people…// it is knowing who to talk to…// he sort of knows where to go to get what…//

5.4.5   Summary of Domain Knowledge and Skills Findings

As illustrated by the preceding data, Clinical Directors perform their role in a complex and somewhat political environment. As doctors, they bring to their role some contextually unique knowledge, skills and attributes. However, the findings also demonstrate that there are deficiencies in some aspects of their performance that need to be improved upon.

Managing professionals in a bureaucratic environment is challenging to even the most experienced professional manager. By virtue of their 'clinical mentality', this task can be all the more difficult for those doctors who venture into management roles. Whilst private sector experience may assist some doctors in understanding management issues, it is their clinical background, political expertise and ability to influence peers that is of the most benefit to them and their organisation.

Like many organisations, hospitals contain a wide range of interests and competing needs. Those doctors who venture into management roles must not only deal with the

political ramifications of such an environment, they must also learn to deal with the dilemma their Hippocratic oath evokes. Balancing financial demands and patient needs in the face of peer pressure is an extremely difficult task. If this dilemma can be overcome, the data suggest that a Clinical Director is superior to a non-clinical manager, in that they can guide their peers and influence change through their clinical knowledge and political ability.

5.5 Business Skills

In their roles as Clinical Directors, many doctors are required to learn or further develop a range of business skills. Some bring these skills from their exposure to the private health sector or their own private practices. For others, they need to be developed from scratch.

According to respondents, the three most important business skills to be learned or refined by a Clinical Director were financial management, strategic planning and human resource management.

BUSINESS SKILLS

Financial Management   **Human Resource Management**

Strategic Management
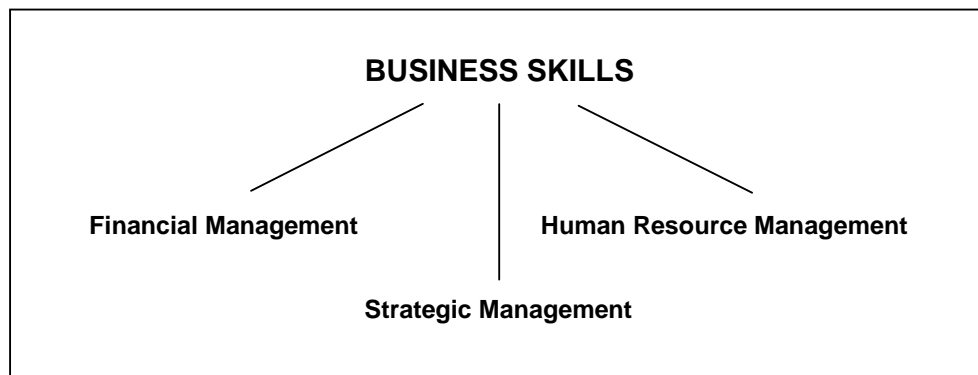
Figure 5.7   Business Skills

5.5.1 Financial Management

Many of the respondents believed that sound financial management skills are an important element of good clinical directorship. The respondents perceived that not only must a Clinical Director be fiscally responsible, but they also must be able to

understand finance, so that they can manage and prioritise human and material resources appropriately.
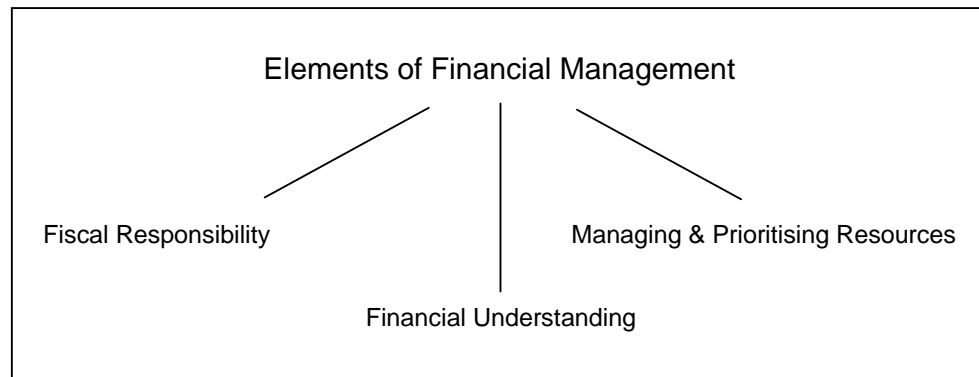
Figure 5.8   Elements of Financial Management

5.5.1.1   Fiscal Responsibility

It became evident that many respondents perceived that they worked in an environment of inappropriate funding, disincentive budget processes and pressing clinical needs.   As a consequence, they perceived that fiscal responsibility has become one of the key markers by which a Clinical Director is judged.

Given such a challenging environment, how is fiscal responsibility measured?   Many respondents believed that a good indicator of fiscal responsibility is success in budget management.   As one Business Manager observed:

The main indicator for their efficiency would be the financial position of the directorate at the end of the year.

Other respondents were of a similar mind:

…// effectiveness is when one comes in under budget … there is a purely fiscal and financial aspect and that is working within one's budget…// effectiveness is measured in terms of balancing your budget … the name of the game at the moment is having a balanced budget …// things like fiscal measures, staying on budget and that kind of thing…// by any measure, we're not efficient at the moment because we're not within budget…//

The difficulty of managing a budget in the face of funding constraints was a common theme among many respondents.

…// the health dollars are somewhat lacking and we always have a shortfall…// Back when I started here, budgets were not a real problem, there was very generous funding for health and over the years I've seen that decline quite dramatically…// it looks like in the next year or two, it's going to be a hell of a lot tougher with funding …, so I don't think that anyone is going to achieve anything really…// it's always a very, very harsh economic environment [in] which we're trying to progress any initiative…//

A number of the Clinical Directors and Business Managers interviewed believe that there simply is not enough money allocated to health.

…// We actually need more money and more resources to efficiently manage the patients…// There are many things that could be done and would be done if we had more funds available…// you could spend ten times as much and still be able to spend more…// Quite simply, we are doing more than we can afford to do…// I think that most of us working in a tertiary institution like this [one] feel that we could be doing more than we do, but we're constrained by costs…//

In contending with this setting, some respondents held the view that funding constraints and unrealistic budgets have made budget attainment a difficult criterion to achieve. As one Clinical Director commented:

I think that [our] effectiveness of course is constrained by the resources that [we] are given and I do think that we've a major problem in that area. I would be a lot more effective if I had more resources to utilise, financial resources predominantly and I see those financial resources in two areas. One is in terms of the hospital's recurrent budget (of keeping the process going) [and the other is] in its capital needs.

Other respondents held similar views:

…// if we had a real budget then I think we could be expected to perform against specific goals…// we can always tell you whether the directorates are running over their budget or not, but that's not a true reflection of efficiency…// they may be very efficient and still outside their budget…//

Some respondents even believed that the budget process appeared to offer a perverse disincentive to remain within budget. As one Clinical Director commented:

The budget planning process and the budget allocation process at the Health Department level are a bit of a shambles. The hospital did quite well last year. It was financially responsible but it hasn't been rewarded. It seems the message the Health Department sends is 'go over budget and we will give you more'.

Others shared a similar cynicism:

…// We were always promised that we would have our own budget and if we made any savings, we could keep them and use them to benefit ourselves – but that hasn't always happened…// Whatever saving we make is never returned to us and that [is] a frustration…// We have made some quite significant inroads into budget savings and so on and we just lose that money…//

According to some respondents, the prospect of balancing a tight budget against pressing clinical needs often proves to be a difficult task for Clinical Directors. As one Clinical Director commented:

In my view, it's not sensible to make a person responsible to the budget. At the end of the day, if there's an overwhelming clinical need, then you have to take this into account.

He went on to recount an example of needing over $1 million of unbudgeted items. He stated:

> *Do I sign the form and put my budget over? I don't hesitate!*

According to one Nurse Manager, such a stance is quite common among doctors. She believed that the stance is a consequence of the clinical mindset of always putting the clinical needs of a patient above all else. She commented:

> *I believe that these days we have to actually justify some of those costs and sometimes we have to look at whether it's effective to spend money in certain areas. I'm not sure whether that actually meets the medical philosophy of their training. I think that there's probably conflict because they are there to try and do the best for all patients.*

5.5.1.2   Financial Understanding

An understanding of the basics of financial management was considered by many of the respondents to be a critical component in successful directorate management. The reason, according to one Clinical Director was quite obvious:

> *I think that ideally [Clinical Directors] should have some background and knowledge about financial issues because most of what the directorates do is based upon the financial allocation for the directorate.*

Others agreed:

> *…// people need to understand the basics of finance administration…// I think that some financial skills…are really essential to run [directorates]…// you have Business Managers, but [Clinical Directors] still need to understand … the financial side of it…// they need to have an understanding of … finance…//*

A number of the respondents, including one Clinical Director, felt that the ability of Clinical Directors to understand financial issues is often somewhat wanting:

…// in my experience, a lot of medical people, for example, are not terribly [good] with finance and the needs of finance people…// A lot of them haven't got a financial background or business background and they have to have - particularly now…// obviously medical staff are not renowned for their financial ability…// I think that where [Clinical Directors] are weak, generally being, [is] the financial side … I think some of the financial issues might potentially [be] an area of weakness…//

However, given the triumvirate structure of directorates, a number of respondents believed that only a rudimentary knowledge of financial management is really required. As one Business Manager suggested:

If they have a non-accounting background, they need some basic financial skills - not accounting skills. They need to understand what a report means to them.

Consequently, many Clinical Directors rely of the expertise of the directorate's Business Manager to provide them with detailed financial analysis.

…// the mysteries of accounting are something that some of us need guidance on…// financial management – that many of us take on advice…// we get plenty of help in this hospital from lots of expert financial people…// they tend to perhaps delegate that sort of work to people who know…// they don't actually have to do it, because that's why they have Business Managers and Nurse Managers …//

However, one respondent strongly believed that the reliance upon Business Managers for financial interpretation would be unacceptable in the future:

There's a tendency to leave the financial side to the Business Manager. I don't believe that's going to be acceptable in the future. Some financial analysis is going to be pretty important because I think you are going to be increasingly financially accountable.

In fact, some doctors already come to the role of a Clinical Director with a financial background and find such knowledge highly beneficial:

…// Certainly I think that having the financial background that I have has helped me in my role so I can only imagine that it would help [Clinical Directors] to become more efficient and be able to interpret things a little bit better…// I had, fortunately, some training, and my exposure of being on the board of a private hospital has made me look more at the finance…//

5.5.1.3 Managing and Prioritising Resources

With a directorate structure, decisions on resource allocation are usually devolved to the Clinical Director. For example, when limits on resource usage are put in place:

The Clinical Director in charge of that [directorate] has to actually go through and talk to the clinicians at the department level and ask how are we going to do [it]?

Thus a key element of successful financial management is the ability to prioritise resources. Clinical Directors, like all managers, must be able to balance the needs of the organisation with the needs of the area under their influence. As one Business Manager commented:

When they end up with the role of a [Clinical Director], they have to be able to look at all the departments that make up the [directorate] and be able to utilise and make the best possible use of what they've got.

This means that, although considered burdensome by doctors, decisions on funding and services need to be fully justified. As one Clinical Director noted:

…doctors are now acknowledging that in healthcare you don't have bottomless pits anymore. That there's far more accountability and an expectation that requests will need to be justified and justified with things such as business plans.

Consequently, tough decisions need to be made. As one Chief Executive commented:

I have to understand that there are clinicians out there crying for money and it's not just for themselves, but it's to the betterment of their patients. But on the other hand, you also have to say, sorry, no it might be great for you, but it isn't in the overall interests of the hospital.

Many respondents believed that an important responsibility of Clinical Directors is to see that the needs of the hospital rather than individuals, departments or directorates are looked after first. As one Clinical Director described:

Efficiency is about setting priorities, working out what is non-negotiable and has to be done and then balancing the rights of other people. You have to balance your resources to where the needs are...

Others agreed:

...// To me it is someone who should be able to know that we have this amount of budget that we are going to work in and sitting down as a team and prioritising and actually looking at what is needed the most. What is going to be the most beneficial to the organisation...// I would see the Clinical Director as being the person who should be pointing staff towards the population needs...// we have identified what we felt were the priorities for the directorate and have started to address those in an appropriate manner...// I think it is the management and understanding [of] where the resources are required and making sure [that] when resources are required in a certain area, there is justification...//

5.5.2 Strategic Management

Many respondents also believed that strategic management is an essential factor of successful clinical directorship. They believed the five most important elements of strategic management to be: having a clearly delineated and empowered role, possessing a strategic vision, strategic planning skills, being able to implement change and the ability to objectively monitor organisational performance using corporate and clinical indicators.
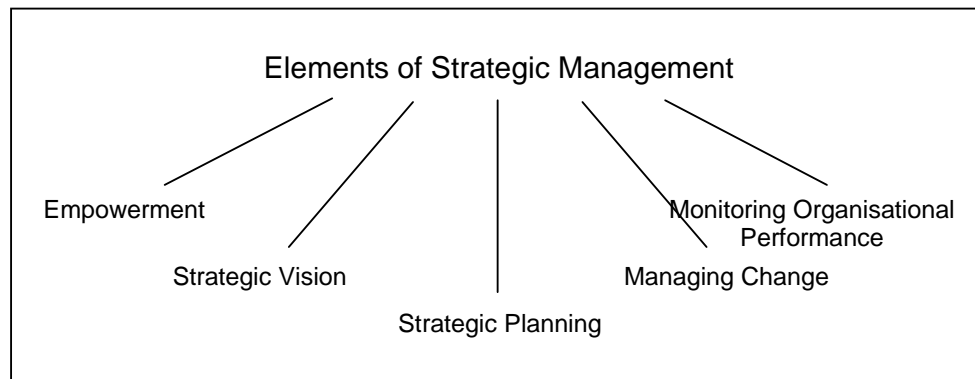
Figure 5.9   Elements of Strategic Management

5.5.2.1 Empowerment

Prior to any involvement in strategic development, a Clinical Director must have a clear understanding of their role within the organisation. Unfortunately, many respondents believed that historical, structural and cultural factors often prevent a Clinical Director's role from being clearly delineated. As one Nurse Manager commented:

It's all about authority. It's about having delegated authority to commit resources. It's about having been empowered to do your job. It's about being trusted to do your job and it's about being able to be open and honest about where your limitations are. If you are able to do that and are supported in making decisions, then you will do okay.

According to many, however, the full delegation of responsibility has never really occurred:

…// Responsibility has never been devolved to the Clinical Directors. There were all these strings that were held on to and the parallel structure remains a problem...// There is a devolvement clinically, but there's hardly any devolvement from a corporate point of view...// they were really at the mercy of everyone else and there were decisions that were made outside of [the] directorate which impacted on the budget, so it was very difficult to manage...// Without that delegated authority, they're very much just a mediator between competing requests. With that authority, I think they do a better job.

A lack of delegated authority and Executive direction has led to confusion over the role of Clinical Directors. As one Nurse Manager commented:

They all had different views about what was expected of them as a clinical leader or Director on Executive. … to a large degree people didn't understand their roles.

5.5.2.2   Strategic Vision

Having a global vision for their directorate, the hospital and healthcare in general was considered by many respondents to be an important dimension of successful clinical directorship. As pointed out by one Business Manager:

… They have to have an overall view [of] where health is going and where it has been so that they can make reasonable decisions that benefit the whole of the service rather than an individual department.

Others felt similarly:

…// it's to do with having appropriate vision for what things might be and how things might be and marrying that with community opinion and political opinion...// From the outset you need to have strategies, strategic plans,

vision…// [they need] a vision of how clinical service delivery should occur in the future and now…// the ones that have a broad vision of the state of health in general and can step from the operational realities of the directorate through to the strategic requirements of the role …//

As such, many respondents believed that Clinical Directors must be able to make decisions that benefit the whole organisation rather than decisions that only benefit their own specialty or directorate:

…// Being able to recognise that even though you think your area is important…someone might have a better case than you do and their need may be more urgent…// I think it is someone who can look outside of their own specific area. That they don't just concentrate purely on what they are…they actually have a broader view about the service and issues…// you have to be prepared to understand everyone's position – of where they're coming from and why they want [things]…// an ability to look at a global perspective rather than a departmental or directorate level is really important…// they have to have the capacity to be a team player as opposed to an individual and have a broader vision than their own specialty…//

Suspicions of vested interests can be extremely damaging to a Clinical Director's reputation. As one Clinical Director commented:

… the other thing about Clinical Directors is that they face challenges in remaining impartial because they have actually come from a clinical discipline. Invariably there's the perception that they're feathering their own nests. Whether or not that is true, I don't know.

Other respondents echoed this thought:

…// one of the problems that they have is sometimes they might have vested interests. Instead of looking at it from an overall perspective, they may be looking at it from one perspective, which is their own specialty…// sometimes

I think there was a bit of emphasis on particular areas that they may have had a personal interest in to the potential detriment of others...// People do look after their own nests...// it is very hard for them when they are running a service not to be biased. I think they are still biased towards whatever specialty it is that they are in and you often find that the specialty may do better - to the deficit of some other specialties...// they're going to want to support their own specialty or specialties within their directorate regardless of the fact of whether or not it is a primary focus of the institution...// they come from diverse backgrounds with diverse opinions and their own directorate's needs foremost in their minds ...// sometimes there's a distinct conflict of interest...//

5.5.2.3 Strategic Planning

Many of the respondents believed that Clinical Directors play an important role in providing strategic direction for the hospital:

...// they're part of setting the strategic direction of the hospital...// they need to manage the more strategic direction of the directorate...// they contribute to the strategic development of the hospital...// they provide the possibility of health services developing strategic plans that are actually formed by them...// they bring a lot of the strategic ... clinical directions to the table...//

Part of the strategic process is being able to clearly identify and prioritise the important issues that exist within their directorate. As pointed out by one Clinical Director:

A Clinical Director who's not across the issues of the departments in his Directorate [and] is not able to represent their issues strongly [to] the senior management of the hospital is not effective as a Clinical Director.

Others held similar opinions:

...// we've identified what we felt were the priorities for the directorate and have started to address those in an appropriate manner, which will express to the wider community that yes, we're an effective directorate because we can see what the issue is and formulate a plan...// in the short time we've had the directorate, he has decided who is going to do what and when and what time frames are attached to that...//

Once a strategic direction has been determined, many respondents believed that a Clinical Director should be actively involved in the planning process with the directorate management team:

...// We also set up action plans...There's a great deal of involvement by the Clinical Director...// We have regular strategic planning meetings, usually at six week intervals [at] which all the staff contribute...// we were able to sit down as a management team and work through what we were all hoping to achieve in the next 12 months...//

As a consequence, business-planning skills were considered to be essential skills by many respondents:

[Clinical Directors] should have business planning development skills. [They] should be able to articulate the goals of the directorate and understand the goals of the departments and where they're trying to go. [They need] to be able to put that into a directorate plan, manage it and ensure that it happens...// you need to have strategies, strategic plans, vision [and] be able to move people forward...// they also need to have some knowledge of strategic planning...// they need to have an understanding of finance and strategic planning...// They need to come up with a strategic plan and a budget that goes with it and they need to sell that...// if you look at some of the attributes ... I think strategic thinking, development of strategic policy and development of innovative methods of delivering care...//

5.5.2.4   Managing Change

Many respondents considered that a successful Clinical Director is one who is able to facilitate and respond to change. According to one Clinical Director:

> *We have to be very flexible and be able to respond to changes.*

Other respondents supported this thought:

> *…// you would be looking at whether they were able to implement change…// looking to see if we were effective in actually implementing a change…// if there's a change of government or a major political policy change, then the goal posts shift and therefore we have to organise and regroup and head towards different goals…// a good understanding of change management…//*

5.5.2.5   Monitoring Organisational Performance

Key performance indicators (KPIs) are identifiable measures of how an organisation performs. In health, KPIs span a wide variety of corporate and clinical functions. Examples range from measures of the average cost per procedure to the number of unexpected ward readmissions over a period of time.

Many respondents believed that a Clinical Director's ability to achieve defined performance indicators is a good indication of their success. As described by one Business Manager:

> *I think the only way you could really assess the Clinical Director's performance is on the basis of the clinical performance indicators.*

Others agreed:

> *…// How do you measure their efficiency? Well I could talk in terms of key performance indicators…// you'd measure how good the Clinical Director*

was on efficiency benchmarks…// I think whether they meet their outcomes. We have goals. For services it is whether or not we meet the benchmarks set by the KPIs…// there are directorate-wide indicators that a Director has to either initiate some work in that area or do part of the work and I guess you can look at those to see if they are being achieved or not…// every unit has three or four PIs and there are the KPIs of the hospital. Those are our subconscious goals that we're trying to achieve…//

Many respondents described both corporate and clinical KPIs that they believed were the most important measures of a Clinical Director's performance. Examples of corporate KPIs include patient complaints, unplanned leave, staff and patient incidents:

…// You would use things like the level of complaints [and] the level of compliments…// The corporate indicators include management of human resources. For example, management of leave, annual leave and other types of leave. Then there [are] also a whole pile of risk management indicators as well. For example, staff injury, patient incidences, workers compensation claims, sick leave indicators…//

Examples of clinical indicators include wait lists times, length of stay, occasions of service and unplanned readmissions:

…// If their resource allocation directly impacts on things like waitlist times, that might be seen as a measure of efficiency…// Patient outcomes, length of stay, bed management – whether they're being used fully, whether or not ED is getting patients shipped through. All the things that we use to measure the whole organisation…// Using things like the KPIs. Looking at our clinical practice, mortality rates, incident management data…// Have you been effectively achieving your goal to reduce the waiting lists or at least keep them stable?…// are you in fact achieving the targets of throughput that you need and I guess one example is waitlist management…//

5.5.3   Human Resource Management

Many respondents believed that the successful management of human resources is an essential component of clinical directorship. The most important elements of this were considered to be leadership, teamwork, conflict management and staff satisfaction.
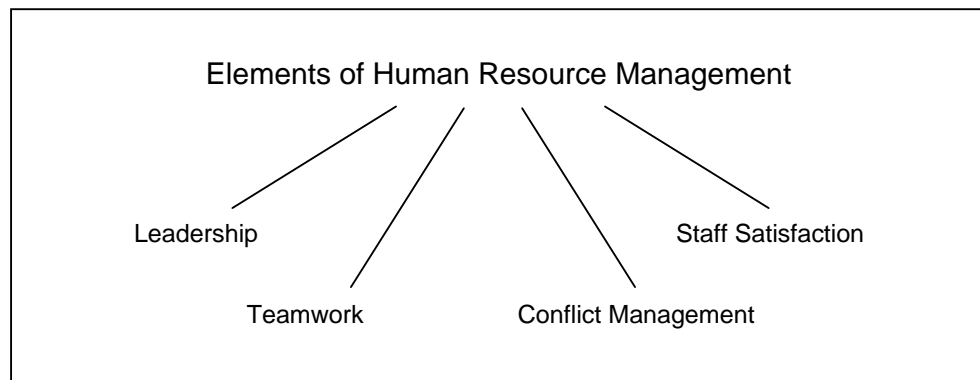
Figure 5.10 Elements of Human Resource Management

5.5.3.1   Leadership

Well-developed leadership skills are an important dimension of clinical directorship. As expressed by one Nurse Manager:

> *…They actually have to perform as a leader.*

Others concurred:

> *…// leadership skills are really important…// it has to be someone who demonstrates that they do have leadership qualities…// I need a degree of forthrightness and leadership…// you need to have leadership skills…// leadership and communication are two of the most important skills they need…// be able to provide leadership…//*

As a leader, Clinical Directors must be a decision-maker rather than a vacillator. One Business Manager described that when:

… a decision has to be made, you know he won't sit on the sidelines at all. He'll look at what the information is before hand and make a decision fairly quickly.

Other respondents had similar experiences:

…// he's one who won't sit on the fence. If there's an issue he'll explore the issue, he'll define a strategy and he'll put that forward…// They've been able to make decisions when a decision is required…// They're very decisive in their response…//

Although an important attribute, a number of respondents believed that Clinical Directors are not particularly good at being decisive. As pointed out by one Business Manager:

… I think that sometimes they duck difficult issues and I think that that's probably because they come from quite a diverse background with diverse opinions and their own directorate's needs foremost in their minds…

Other non-Clinical Director respondents felt the same:

…// I've been sitting around a table that still is unable to make a decision. They get to a point where they can't make it because they know they'll come to the table representing their situation and if they're seen to be persuaded … that there are bigger issues, they get to a point where they can't make decisions so no decision is made or it is left to somebody else…// …they don't feel comfortable to be able to stand up in a management meeting and say 'I believe in such and such'… There have been times when the hospital has been under extraordinary pressure for one reason or another and they chose not to meet because 'they had nothing to discuss' and we've all found that to be absolutely amazing…//

5.5.3.2 Teamwork

Many respondents believed that a successful Clinical Director must be able to foster teamwork within their directorate. As one Business Manager commented:

… They need to have some background in human resource management. Knowing how to get the best utilisation out of staff, how to motivate staff, how to foster teamwork.

Others agreed:

…// The human resource side has to be done properly…// obviously you need to have people management skills…// able to come to the table with knowledge of human resource systems…// Being managers in business terms – I mean management and personnel skills as well…// you have to actually pull people together into a team…// it is fine to be an outstanding doctor but unless you actually know how to lead a team there's no point stepping into a Clinical Director role…// you should have team management skills…//

Similarly, many respondents believed that a Clinical Director must be able to successfully function as part of a management team. As one Business Manager suggested:

Each of us had different skills and experience and he accepted those skills and experience. If there [were] a nursing issue, he would be looking [to] the Nurse Manager to provide him with advice. If it was a business issue to deal with finances, resources or putting up submissions, he would be looking [to] me to provide him with that advice and often as a team we would make the decision.

Others agreed:

…// we always strive to make sure we work as a team…// I think it's a team effort…// you have to work as a team member…// they know how to be a team player…//

Many respondents believed that a Clinical Director's success is underpinned by the working relationship they have with their management team. With many Clinical Directors being sessional or part-time, the relationship that exists with their Nurse Managers is of particular importance. As one Clinical Director pointed out:

I've gained a huge amount of experience from my Nurse Manager who is in the position full-time and does most of the day-to-day work.

Others supported this view:

…// the Clinical Director still needs to work very closely with the Nurse Manager and we've had some good relationships with that and I think that helped or I know that that helped. It has made a big difference particularly to those who weren't here full time…// I think a vast majority of the Clinical Directors were pleased or grateful that there was a Nurse Manager that they could trust and rely on and who was there every day of the week and generally kept the show on the road…//

Trust in their working relationship offers Clinical Directors the confidence to delegate decision-making to their management team. As one Nurse Manager commented:

The Clinical Directors tended to see their management teams as their Executive and knew that they didn't need to be there. Things continued to run. Provided they were apprised of what was going on, it wasn't really an issue.

Others were of a similar opinion:

…// He's very happy to delegate responsibility. He's not a control freak as long as we keep him informed about the progress of things and go to him with issues and problems…// They would empower their management team…// I had to say that we haven't had a chance to talk, so you're going to have to trust the decisions that I'm making and back me – and he does that…//

However, such trust can only be gained if both the Clinical Director and his management team work together with a common focus. As one Nurse Manager suggested:

I see it as a joint role, so in order to determine that the Clinical Director is efficient, I actually have to be efficient.

Others agreed:

…// they seem to be in harmony in what they do, they are very like-minded in the direction that they take…// effectiveness of the Clinical Director is [when] the Clinical Director and Nurse Manager have spent time prior and are prepared to have a single point of view and go forward in the same direction…// effectiveness…is very pivotal on the teamwork that occurs…// we are very much part of a team together…// it is that collaboration and that teamwork…//

A number of respondents believed that the primary roles of a Clinical Director are to provide vision and direction. Many believed that the day-to-day running of the directorate should mostly be left to the Nurse Manager and Business Manager. As such, respondents believed that a good Clinical Director is one who utilises their management support team appropriately. As one Nurse Manager suggested:

You seem to have a partnership where a lot of the strategic clinical direction may come from the Clinical Director and certainly is influenced by the Nurse Manager and the Nurse Manager tends to perhaps make it happen.

Other respondents agreed:

…// the ones that I think have done the best have provided the senior role, providing guidance and leadership rather than being involved in the day-to-day operation. Getting involved if they have to, but basically letting the Nurse Manager and the Business Manager handle the day-to-day running of it…It is generally, I think, the medical person who provides the guidance and whereabouts you go…// What I'm looking for is someone who has the ability to work closely with a Nurse Manager, accepts equal responsibility but given that the Clinical Director is not here all the time, they allow the Nurse Manager to be the main player in terms of the day-to-day operational management…// the Clinical Director identifies his vision, … runs it past me, I work with him. You see what it is, but I make it happen. I'm the enabler. He can't enable, only because he does two sessions per week and because he doesn't have the time to understand the system … that becomes critical to have my ability as an enabler and to make it move forward…//

Some respondents slightly differed with this view. They believed that in addition to utilising their management team's skills, a good Clinical Director should be actively involved in the operational management of the directorate. As suggested by one Clinical Director:

I believe it's important that the Director have direct input in the day-to-day activities within the directorate.

Others believed the same:

…// [their] business skills would be operational, a very good ability to see the macro world as well as an interest in micro-activities…// active involvement in the ones he needs to be physically involved with…// a soft measure of effectiveness is how much do these people participate in the organisational workforce of the hospital?…//

A number of respondents suggested that doctors tend to find the task of managing staff to be a difficult one. As one Head of Department pointed out:

Medical Practitioners who have moved into management roles without special management training have struggled in some cases because they tend not to have the people skills and general organisational skills that are required for that sort of work.

Others agreed:

...// I think [personnel management] is pretty important and often done very badly. People aren't taught how to do it...// there have been some medical management people that I've observed over the years who are not competent enough as managers, particularly people managers...//

A number of the respondents suggested that part of successfully managing people involves having a tolerant and understanding outlook. As expressed by one Chief Executive, he looks for a Clinical Director who has:

...a willingness to learn about working with people. [It's] about managing people, their expectations and difficulties, but managing in a way that makes sure there is a degree of harmony and common sense.

Others felt similarly:

...// they have to be reasonably good people and they have to have common sense...// you have to be prepared to understand everyone's position...// you really need to be patient and not become entirely intolerant...// they need to be politically astute and fairly flexible in the attitudes...//

Unfortunately, a number of respondents believed that Clinical Directors often lack this particular attribute:

...// they aren't willing to listen to other's opinions...// They just focus on one small area. They don't see the people outside and what they have to offer...//

My vintage of graduates were taught to make all the decisions by ourselves so there was no hint of teamwork ever taking place...// Medically qualified people tend to be pretty much [be] their own people and once they've set their sights ... go for it hard without considering ... all the other implications, which they need to look at...// they don't tend to be quite as accepting...//

However, the devolution of management has seen these deficits overcome with appropriate training. As a result, the future, according to one Head of Department, is looking promising:

I think we're going to find a new, different breed of medical practitioner over the next 10-20 years coming into leadership roles. It will be the type of people who will be able to manage other people pretty well – better than us I would think.

5.5.3.3   Conflict Management

A number of respondents believed that the ability to resolve conflict is an important dimension of clinical directorship. But why does conflict occur? As one Clinical Director pointed out:

… in a hospital not only every department, but every single clinician in the hospital believes what they do is more important than what anyone else does.

As a consequence, one Clinical Director suggested that the principal requirement of his position was:

Being able to problem solve when there's a problem. Dealing with interpersonal issues and how to handle day-to-day conflicts is important.

Other respondents felt similarly:

…// You need to have...conflict resolution type skills...// they need to have excellent communication, interpersonal, conflict resolution skills...// how to resolve issues such as personal issues within a department...//

When dealing with interpersonal conflict across departments, one Clinical Director believed:

You have to be able to resolve those issues one way or another, whether they are small or big before they get huge...if there's the development of interpersonal problems within a department, it basically paralyses the department.

Many respondents considered that dealing with these issues in a timely manner is an important criterion for successful clinical directorship:

...// my criteria for efficiency is that once we do identify problems, that we can actually get on top of them and that we resolve the problems and they don't go on and on ...// the first [Clinical Director] I had, I thought was very efficient and again, timeliness was there...// To answer in a very timely manner and appropriate...//

5.5.3.4   Staff Satisfaction

Many respondents considered the ability to achieve and maintain staff satisfaction was an important dimension of good clinical directorship.

A number of respondents pointed out that the recruitment and retention of staff are important indicators of staff satisfaction. For example, when asked to comment on how one would judge a Clinical Director to be efficient, one Business Manager remarked:

… things such as retention of staff, recruitment of staff and possibly the development of clinical academic programmes. I think they would be seen as direct indicators of the effectiveness of Clinical Directors.

Others agreed:

...// one could look at the effectiveness in things like staff potential, people who are all of a sudden leaving in droves because they can't work with these

people…// you can judge that by people wanting to come and work here and stay and not leave…// people leaving the directorate and moving to other directorates, or worse case scenario, actually leaving the hospital and moving to other sites. That indicated to me the lack of his ability to manage…//

Similarly, staff morale was seen as an important indicator:

The internal morale of the place deteriorated and that to me was the first indicator that the system was not working or [that] direction was not forthcoming.

From a positive perspective:

…// If the Registrars, Residents and Nursing Staff all like to work within that department, that usually means that it is working well…// People keep putting in the extra bit of effort and the extra bit of distance to get things right…//

Absenteeism, whether by way of increased sick or even annual leave, represented to many respondents, problems with staff satisfaction. As one Business Manager commented:

… in the previous directorate we found that the absentee rate went up when we changed Directors.

Other respondents noted similar trends with under-performing Clinical Directors:

…// There was a significant increase in people taking leave, taking sick leave…// there seems to be increased leave taken, increased staff on sick leave, high levels of illness within the department…//

5.5.4   Summary of Business Skills Findings

As shown by the preceding data, the efficiency and effectiveness of Clinical Directors is often judged by their level of skill in performing standard management functions. In a healthcare environment that consists of funding constraints and pressing clinical needs, a successful Clinical Director is perceived to be one who is able to manage their budget without compromising the quality of patient care.   Unfortunately, unrealistic budgets and disincentive budgeting processes generate a high degree of cynicism and frustration among Clinical Directors. Added to this are the frustrations and confusion caused by parallel management structures, lack of devolution of authority and ambiguous roles.

Clearly, those who take on clinical directorships have to deal with a complex and difficult environment. The data suggest that mastering various financial, strategic and human resource skills are essential in dealing with this environment.

Many respondents suggested that an understanding of finance was a prerequisite of successful clinical directorship. However, the depth and breadth of understanding was subject to varying opinions. Whilst some respondents believed that a detailed understanding of finance is beneficial to a Clinical Director, others felt that only a basic understanding is required and that the expertise of the directorate's Business Manager should be used to assist with detailed interpretation.

The principal role, suggested many of the respondents, should be to provide vision and direction for the hospital.   Operational issues should be delegated to the directorate management team. Most importantly, suggest the data, the vision should be organisation-wide and not focussed upon vested directorate interests.   The successful Clinical Director must be able to make hard decisions, provide leadership and prioritise resources in a fair and balanced way.   They must be able to foster teamwork, manage change, be flexible and respond appropriately to the needs of all.

The Clinical Director's role requires them deal with a variety of professional staff. Mostly untrained in human resource management, the data suggest that they often

find it difficult to deliver bad news and deal with conflict. Lack of tolerance, suggest some respondents, exacerbates this problem.

5.6 Personal Attributes

The very nature of management means that Clinical Directors bring a number of intrapersonal attributes and interpersonal skills to the role they perform.   The respondents considered the most important intrapersonal attributes to be commitment and participation.   The most important interpersonal skill perceived by the respondents was communication.

Personal Attributes

Commitment & Participation   **Communication**
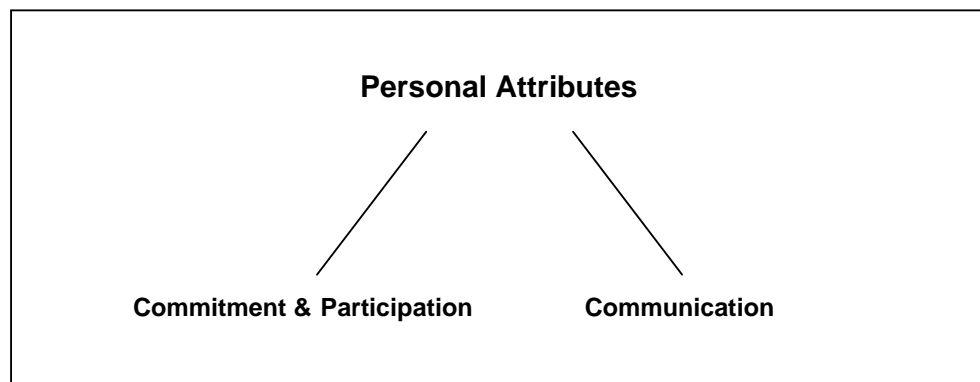
Figure 5.11 Personal Attributes

5.6.1 Commitment and Participation

Many respondents considered a Clinical Director's commitment to both their role and the organisation to be essential contributors to their success. The most important aspects were thought to be dedication, sufficient time allocation and active participation.

Elements of Commitment and Participation

Organisational Involvement   Allocation of Time

Dedication
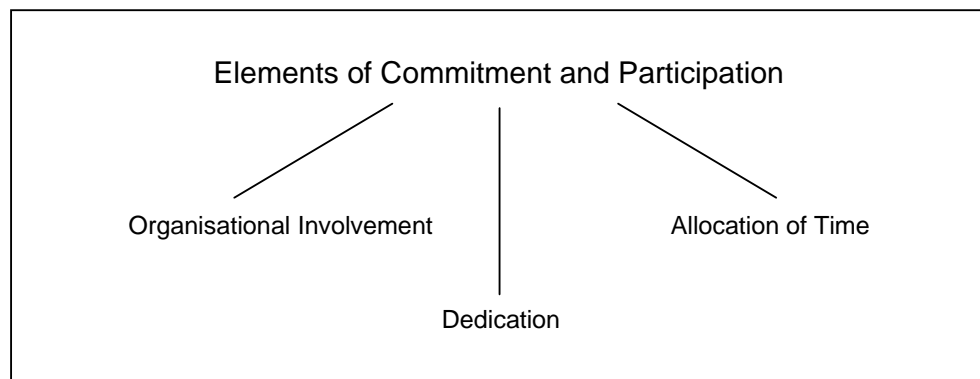
Figure 5.12 Elements of Commitment and Participation

5.6.1.1 Organisational Involvement

Involvement in the management process and organisational commitment are attributes that were considered important by many of the respondents. As one Clinical Director pointed out:

There's a sense now [of] the need to participate more vigorously...You do have to stand up and deliver.

Others agreed:

...// the desire to participate and be present is very important...// there [are] a lot of clinicians that are taking more interest and want to know more [on] how to develop business plans and they're more interested in the strategic planning process of the hospital...// doctors are a lot more vocal now about what they want, how they want it and where to get it and want to be part of the decision-making...// they want to become more involved and I think that they've recognised that they do have a part to play and a contribution to make in the future direction of hospitals...//

The commitment must be to the whole organisation rather than just their directorate or specialty:

...// wanting to see the whole organisation grow rather than just their particular specialty...// I do believe that they're committed in terms of the involvement in the hospital and their interest in it...// they need to put up their hand and say I want to roll up my sleeves and get down and dirty and try and sort out [issues] and have an influence on the way the hospital is evolving...//

5.6.1.2   Dedication

The role of a Clinical Director is a difficult one and without dedication, little would be achieved. Many respondents agreed that to be successful, a Clinical Director must want to take on the role. As suggested by one Clinical Director:

I think if you are going to be good at it, you have to want to do it

Other agreed:

…// you have to want to be involved…// I've been fortunate in that I've a Clinical Director who wanted the job…// the Director wanted the job…// …someone who wants to do it and sees it as a challenge because it's a very demanding role…// …someone who is interested in doing it and there aren't that many of them…// …willingness to take on the job…// They actually need to have a willingness and an understanding of management and a need and a want to participate…//

Many respondents believed that successful Clinical Directors also bring passion and enthusiasm to the role:

…// each of them had a passion for their job…// they have to be enthusiastic about their role in administration…// They're very enthusiastic…// the ones that I've seen that have done really well are ones who are passionate…//

They also believed that with such qualities and a typically demanding role comes much hard work:

…// you have to be very hard working and motivated…// the Clinical Directors that are currently on the Executive are all very hard working people who are committed to the job…// they tend to be extremely hard working…// They're hard working…//

5.6.1.3   Allocation of Time

One of the biggest challenges that a Clinical Director faces is dedicating sufficient time to their managerial role, whilst still maintaining a busy clinical workload. As one Clinical Director remarked:

I think the problem has always been (and I think it still is) that if you're a clinician such as I am and you have a very substantial clinical load and you run a directorate that includes essentially four departments, it is pretty hard to get it all done.

Others agreed:

...// time is an issue. A lot of them probably would say that they don't have enough time to do all the things clinically and administratively that are required of them...// One of the issues of the Clinical Directors is the time that they have available to the role...// Lack of time is another obstacle...// they all have time problems...// they're all acting clinicians still, so they always will have a competition for time...// they aren't given enough time to undertake the challenges and solve the issues that exist...//

A number of respondents felt that having a part-time or sessional commitment to the hospital does not allow sufficient time to be allocated to the managerial component of a Clinical Director's role. As one Business Manager pointed out:

I think that it is an important role that they have and I think that most Clinical Directors in health probably only have two sessions to do that and that is not a lot of time to work internally within the directorate plus have a broad focus within the hospital.

Others supported the thought that the number of sessions devoted to management are too few:

...// our Director is 0.2 fte. Meetings would take up all of his time. No time for management...// one of the limiting factors is the amount of time that they are actually in the hospital...// the biggest hindrance I always thought was

the fact that they were part-time…// whilst they tried very hard, they were still only here part-time so they weren't around a lot of the time…//

A number of respondents believed that the role demanded a full-time presence:

…// they generally need to be full-time at the hospital…// someone who was in the hospital full-time and I think that makes a very big difference…// could be a full-time job without any doubt…// I think that we need to have Directors more engaged in directing. I mean full time…//

Others simply felt that Clinical Directors' clinical workloads were far too heavy for them to devote the appropriate amount of time to the managerial component of their job:

…// I think from a medical leadership point of view that the Clinical Directors have too much clinical contact. They really should have been more in the management role…// most of them have very heavy clinical commitments, which is a limiting factor…// the biggest hindrance is having a clinical workload…//

Some respondents believed that Clinical Directors aren't really prepared to sacrifice their clinical practice despite needing to allocate more time to the managerial component of their job. As one Nurse Manager pointed out:

…most clinicians don't appear to want to give up a large percentage of their clinical role.

Others agreed:

…// first and foremost they're doctors and that's what they're here to do and they want to be doctors rather than managers…// a lot of them want to maintain their clinical workload. It becomes very difficult for them to find time to give to the directorate and the Clinical Director's role…// a lot of clinical people find it difficult to assign the necessary time and resource to meeting some of their administrative roles. The call, so to speak, of the clinical area will always dominate…//

Being unable to devote the appropriate amount of time to the role, much of the responsibility of running the clinical directorate falls upon the Nurse Manager and the Business Manager:

...// their clinical demands are such that they cannot spend the time that they need to do the job well, so the majority of the day to day responsibility does fall on the Business Manager and the Nurse Manager...// Often, the day-to day stuff the Nurse Manager and the Business Manager just get on with...//

5.6.2   Communication

Many of those interviewed considered communication to be an important element of successful clinical directorship.   The essential aspects of this were being communicative, listening and interacting.
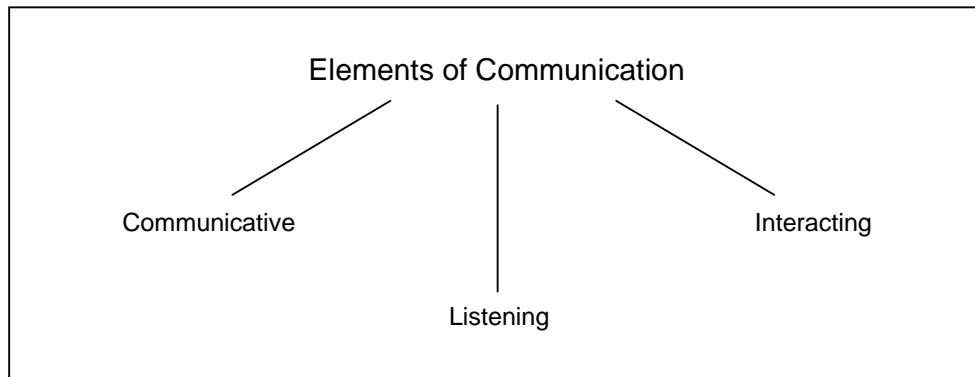
Figure 5.13 Elements of Communication

5.6.2.1   Communicative

Good communication skills were considered by many respondents to be essential for good clinical directorship. As suggested by one Nurse Manager:

...they need to be [a] good communicator. They have to be extremely good communicators.

Others felt similarly:

…// They need to have excellent communication, interpersonal and conflict resolution skills…// they need to be very good communicators…// communication skills are absolutely vital for them…// communication is another huge skill…// leadership and communication skills are two of the most important skills they need…//

Many respondents believed that a good Clinical Director must be able to effectively communicate at all levels throughout the organisation:

…// you need to be a good communicator with people at all levels…// the ability to communicate very clearly to their peers at a very high level is very important…// it's the Director's responsibility to provide information to the Heads of Departments…// good Clinical Directors are able to facilitate discussion…// they need to be able to put their case forward in different forums … they [could] be talking to people without a clinical background and I think they have to develop those skills…// they would be communicating well with [the] Executive…//

Some Clinical Directors received plaudits:

…// his communication is good, he will always inform us about what's going on and how that might impact upon us, he communicates with other people within the directorate very well…// he has been a very open communicator. He's taken [issues to] the hospital Executive, took from them and fed back. He's kept good lines of communication open…// he's communicated extremely well to the Corporate Directors and to the hospital Executive…// he's made an effort to be a good communicator…//

Other Clinical Directors' communication skills were not quite so revered:

…// doctors are obviously seen by the public and many people as being leaders, but in many situations their communication and leadership skills are very poor…// I wouldn't call them all good communicators…//

5.6.2.2 Listening

A number of respondents suggested that to be successful, a Clinical Director needs to be a good listener. As pointed out by one Business Manager:

…the performance is good simply because the [Clinical Director] listens to people's requirements and suggestions…

Others agreed:

…// they have to be able to listen…// all the departments are pretty happy with the way they get listened to…// you have to be able to listen…// to be able to listen and take an interest in the goings on…// a preparedness to listen…//

5.6.2.3 Interacting

Many respondents believed that it is important for a Clinical Director to be engaged with the workforce. As pointed out by one Clinical Director:

[Clinical Directors] have to have an open door policy whereby individuals can approach them with issues. [They] have to be prepared to have regular meetings with their team and they have to work as a team member.

Others agreed:

…// effectiveness for the position is demonstrated by good relationships with the Heads of Department…// talk to everyone and find out what they want to do…// the desire to participate and be present is very important…// from the outset you need to … move people forward, getting their views…//

The introduction of clinical directorates has offered staff a greater opportunity to interact with their Executive. As one Business Manager observed:

…staff were able to relate to them, and a lot closer to the scene, than say the previous Director or previous Executive if you like. … the fact that it was so nice having someone who was very close to the scene, so there were

practicing clinicians who understand some of the operational issues, whereas the previous Executive were far too removed. There seemed to be a big gap between the staff and the Executive, whereas at least when Clinical Directors were here, they were members of the Executive. Staff would approach them about any issue and they would take them on board.

A number of the Clinical Directors felt that ease of access and close interaction with their staff was vitally important in order for them to perform their role successfully. As one Clinical Director pointed out:

They need to feel that they can always come and knock on the door and either speak with you or find you or find out where you are so they can talk to you.

Others agreed on the importance of good staff interaction:

…// interaction, the ability to get on with people, your ability to get things done and keep regular contact with your staff…// the most significant part of the role is to be present, to be visible, to be able to have that dialogue…//

5.6.3   Summary of Personal Attributes Findings

As has been demonstrated in the preceding section, the successful Clinical Director brings to their role a number of important personal attributes. The data would suggest that one of the most significant attributes is commitment to their role. In accepting an Executive role, it is particularly important that their prime commitment is to the organisation rather than their directorate or specialty.

From an intrapersonal perspective, the data shows that an efficient and effective Clinical Director must be willing to take on the challenges of a demanding and time-consuming role. They must be hard working, enthusiastic and have a burning desire to make a difference. The data suggest that the amount of time many Clinical Directors allocate to their directorship is insufficient and that a portion of their clinical commitment should be sacrificed for the management role.

From an interpersonal perspective, a successful Clinical Director is one who is able to communicate well at al levels across the organisation. Unfortunately, the data suggest that the standard of Clinical Director communication varies significantly from good to bad.

Being an Executive who works at the coalface offers a unique opportunity for staff to interact with someone who can make strategic decisions and influence change. The data suggest that being prepared to listen and have an open door policy can be particularly good for staff satisfaction and morale.

5.7 Chapter Summary

Analysis of the transcribed interviews revealed that the respondents perceived that there are three dimensions of efficient and effective clinical directorship. They are: those that are brought to the role by doctors and governed by the health environment in which they develop **(Domain Knowledge and Skills)**, those that are learned **(Business Skills)** and those that are innate **(Personal Attributes)**.

As shown by the following diagram, the three perceived dimensions of an efficient and effective Clinical Director comprised nine components: Clinical Expertise, Peer Influence, Political Expertise, Environment Knowledge, Financial Management, Strategic Management, Human Resource Management, Commitment & Participation and Communication.

DOMAIN KNOWLEDGE AND SKILLS
Clinical Experience
Peer Influence
Political Expertise
Environment Knowledge

BUSINESS SKILLS

Financial Management
Strategic Management
Human Resource Management

PERSONAL ATTRIBUTES

Commitment & Participation
Communication
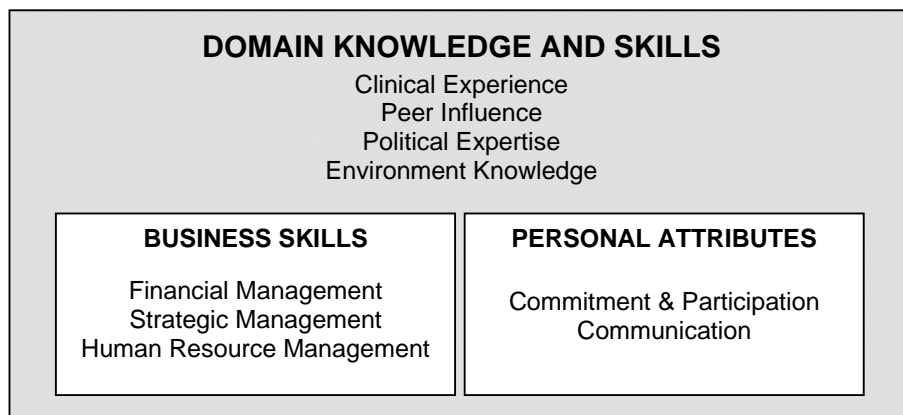
Figure 5.14 The Nine Components of Efficient and Effective Clinical Directorship

The dimensions, components and elements of efficient and effective clinical directorship are illustrated by the following figure:

Domain Knowledge and Skills

Clinical Experience

Current Practitioner
Clinically-based Decisions
Clinical Governance
Evidence-based Decisions
Quality Focused

Peer Influence

Peer Management
Credibility & Respect
Resolve

Political Expertise

Political Astuteness
Negotiation Skills

Environment Knowledge

Knowledge of Public Sector Processes
Knowledge of Organisational Operations

Business Skills

Financial Skills

Fiscal Responsibility
Financial Understanding
Managing & Prioritising

Strategic Skills

Empowerment
Strategic Vision
Strategic Planning
Managing Change
Monitoring Organisational Performance

Human Resource Skills

Leadership
Teamwork
Conflict Resolution
Staff Satisfaction

Personal Attributes

Commitment & Participation

Organisational Involvement
Dedication
Allocation of Time

Communication

Communicative
Listening
Interacting

Figure 5.15 The Elements of Efficient and Effective Clinical Directorship

Chapter 6 Discussion

6.1 Introduction

This chapter begins with a discussion on managerial efficiency and effectiveness. The discussion outlines criteria by which managerial success can be assessed and then continues to discuss how managerial roles and skills interact in order to generate efficiency and effectiveness. The discussion proposes that for an organisation to move forward, managerial effectiveness is to some extent, more important than managerial efficiency.

The chapter then proceeds to introduce an emergent model of Clinical Director efficiency and effectiveness, which has been termed the Clinical Director Efficiency and Effectiveness (CD2E) model. The emergent model is representative of three dimensions of Clinical Director efficiency and effectiveness. The first dimension designated 'Domain Knowledge and Skills' is contextually specific to the directorate environment and characterises those unique components that doctors bring to the management process. The second dimension, termed 'Business Skills', has components that are vitally important, yet common to almost all executive and management positions. However, a perceived lack of expertise by doctors in some of these skills makes them important factors for development and training. The third dimension, 'Personal Attributes', highlight those intra- and interpersonal skills that are required or brought by doctors to the Clinical Director role. Some of these skills (such as commitment) are determined by contextual and domain factors, whilst others (such as communication), are innate. A discussion of these three dimensions and their components follows with reference to the findings and literature on the topic.

The chapter concludes with a discussion how the emergent CD2E model can assist in the identification and development of competencies and skills required for successful clinical directorship.

6.2   Managerial Efficiency and Effectiveness

It is commonly accepted that the ideology of New Public Management has affected the development of hospital management over the past two decades. The emphasis for this ideology has been results-oriented management.   Managers have been required to 'do more with less' and 'focus on outcomes and results'. In other words, managers have been required to focus their management of human and financial resources, on the '2Es' … efficiency and effectiveness (Lee Hiu-hong, 2000).

The basic purpose of management, suggests Griffin (2002:8), is to ensure that …

"…an organisation's goals are achieved in an efficient and effective manner."

Occasionally in management circles, the terms efficiency and effectiveness are used almost interchangeably. However, this should not be the case. As Drucker (1963) proposes, efficiency is about 'doing things right' whilst effectiveness is about 'doing the right things'.

Being the two dimensions of performance (Hovenga, 2004), efficiency and effectiveness are often used as a measure of a manager's success. To paraphrase Drucker (1963), a successful manager is one who … does the right things, right first time. To be efficient, a manager must utilise resources wisely and in a cost-effective manner, whereas to be effective, a manager must make the right decisions and successfully implement them (Griffin, 2002).

Measures of managerial efficiency in a hospital setting focus on clinical performance indicators such patients treated per annum, number of bed days per patient or length of theatre waiting lists and corporate indicators such as budget expenditure, staff turnover or cost per diagnostic related group.

In the hospital setting, measures of managerial effectiveness include introducing new medical services or technology, increasing bed numbers or participating in cutting edge research.

According to Robbins (2003), successful management involves the efficient and effective completion of organisational work activities. A hospital manager, for example, is efficient if they can provide hospital services at a low cost. They are effective only if the low cost services fully meet the needs of their patients (Robbins, 2003). As can be seen, efficiency and effectiveness are concepts that go hand-in-hand. It is no good for a hospital manager to improve efficiency by reducing the average number of days a patient occupies a bed, if effectiveness is compromised through a higher number of medical complications.

Although managers are required to be both efficient and effective, Israeli (2007) suggests that for the most part, managers are not that good at being efficient, effective or both. The following matrix offers a good illustration as to how a manager's efficiency and effectiveness relates to the meeting of objectives and the use of resources. In this matrix, the area of true managerial success is represented by the upper right quadrant where both efficiency and effectiveness are achieved.
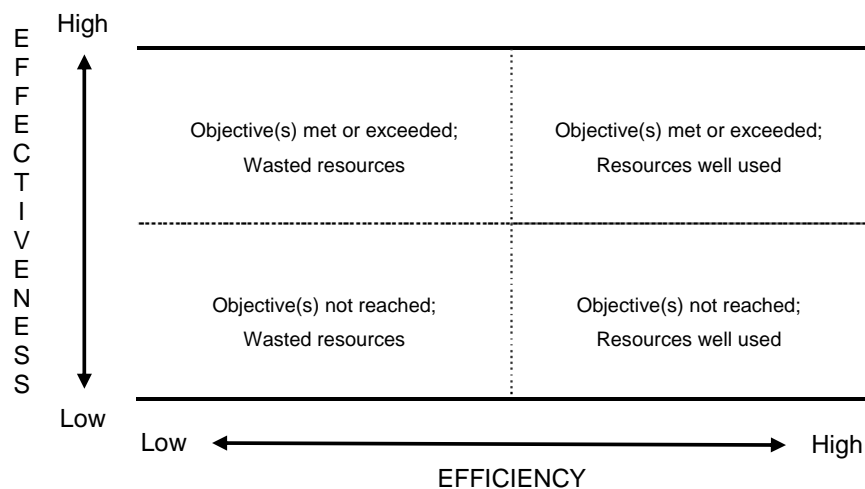
Figure 6.1   The Efficiency - Effectiveness Matrix
Source: Mosley et al (1996:25)

6.3   Efficiency, Effectiveness and the Management Process

The basic premise of management is described by Griffin (2002) as the achievement of organisational goals by efficiently and effectively combining human, financial, physical and information resources through the use of basic managerial activities such

as planning and decision-making, organising, leading and controlling. Although this description may appear quite verbose, the process is well illustrated by the following figure.
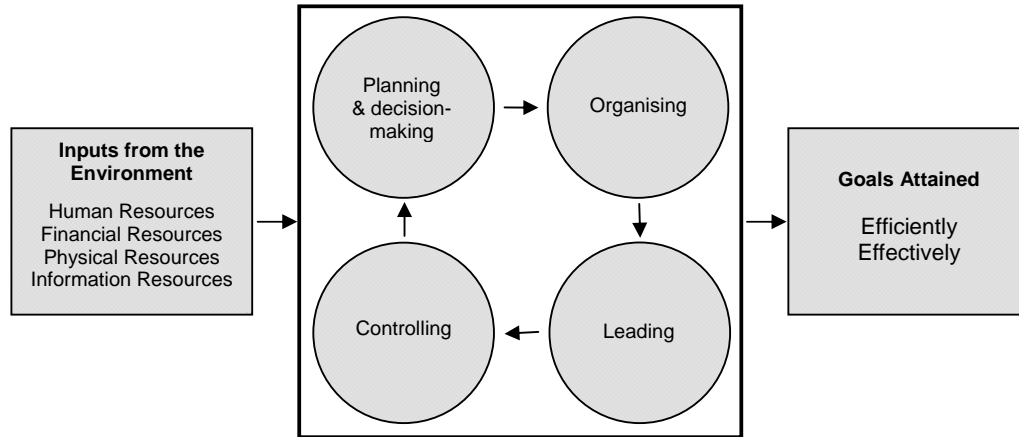
Figure 6.2   Efficiency, Effectiveness and the Management Process
Source: Griffin (2002:8)

As suggested by Griffin (2002), the characteristics that contribute to the complexity and uncertainty of management tend to stem from the environment in which the organisation operates. Hence, it is critical for the successful managers to understand the environment and the resources it provides. The above figure illustrates how a manager takes those resources and applies a range of skills (planning and decision-making, organising, leading and controlling) to successfully carry out the management process.

Israeli (2007) points out that the determinants of managerial efficiency and effectiveness vary according to the type of industry being assessed. For example, in the product industry, where goods are produced and then consumed, efficiency and effectiveness tend to largely be determined by objective measures. However in the service industry, where services are produced and consumed simultaneously, efficiency and effectiveness tend to be more subjectively determined.

The answer to the question of what makes a manager efficient and effective has intrigued researchers for decades. The Mintzberg (1989) model of managerial roles

proposes that the combination of interpersonal, informational and decisional roles will generate efficiency and effectiveness. However, whilst Mintzberg (1989) proposes that managerial efficiency is an important endeavour, he comments that it is managerial effectiveness that drives an organisation forward.

6.4   The CD2E Model

The emergent Clinical Director Efficiency and Effectiveness (CD2E) model offers a three-dimension model of what is perceived to be the requirements for an efficient and effective Clinical Director. The dimensions have been designated Domain Knowledge and Skills, Business Skills and Personal Attributes.

<div>

DOMAIN KNOWLEDGE AND SKILLS
Clinical Experience
Collegial Influence
Political Expertise
Environment Knowledge

BUSINESS SKILLS	**PERSONAL ATTRIBUTES**
Financial Management Strategic Management Human Resource Management	Commitment & Participation Communication

</div>
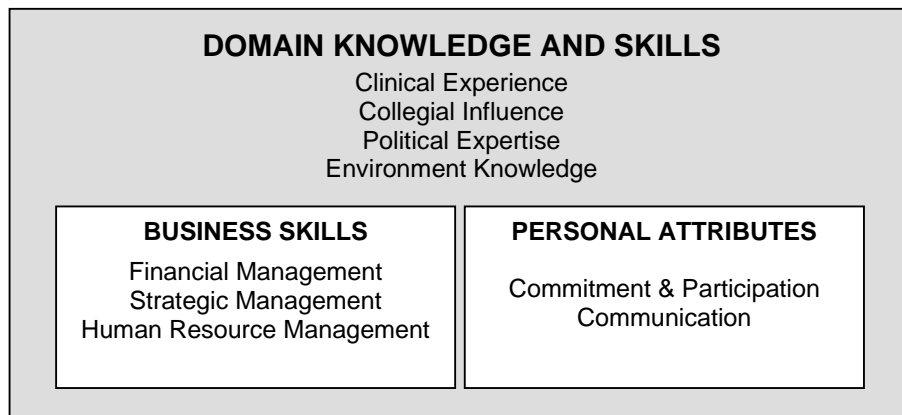
Figure 6.3   The CD2E Emergent Model

The emergent model suggests that in the unique healthcare environment, doctors bring context specific knowledge and skills to the role of a Clinical Director. These include: clinical experience, collegial influence, political expertise and environment knowledge.

According to the emergent model, the efficient and effective Clinical Director must bring to their role sufficient clinical experience to support their management decisions. A Clinical Director must be a current practicing clinician who understands the concepts of clinical governance. Their decisions need to be evidence-based with a focus on quality.

The emergent model suggests that a mature level of political expertise within the hospital context is an important domain skill for a Clinical Director. The efficient and effective Clinical Director needs to understand hospital politics and be sufficiently astute and credible in that context to influence outcomes. Well-developed negotiating skills complement their political astuteness. In the current environment, a Clinical Director must be able to successfully negotiate for scarce physical and financial resources.

The efficient and effective Clinical Director is one who is also able to exert peer influence. To do this they must be able to command credibility and respect from their medical colleagues. These attributes allow a Clinical Director be confident and assertive in dealing with them.

The remaining domain skill suggested by the emergent model is environment knowledge. To be efficient and effective, it is suggested that a Clinical Director should have a sound knowledge of public sector processes such as policy and standards, an insight into public sector bureaucracy and an understanding of how the hospital works at all levels.

The emergent model suggests that in order to be efficient and effective in their role, Clinical Directors must also learn or develop specific business skills. The most important business skills were considered to be in financial, strategic and human resource management. Such skills are common to almost all executive and management positions, in particular, those that are of a level and complexity required of clinical directorship.

Given that Clinical Directors must manage in an environment of competing needs and stringent budgets, their efficiency and effectiveness is in part determined by their financial skills. The emergent model proposes that their financial skills are underlined by fiscal responsibility, an understanding of the elements of finance and an ability to manage and prioritise the resources under their control.

Being responsible for large budgets, complex processes and scores of staff, the emergent model proposes that a Clinical Director must also be well versed in strategic management. They must be a visionary who possesses a selfless global vision for health, the hospital and their clinical directorate. From an operational perspective, an efficient and effective Clinical Director must be able to plan strategically, implement change successfully and measure performance appropriately.

The ability to efficiently and effectively manage human resources is the third of the emergent model's set of business skills. A Clinical Director must exhibit leadership qualities and as such, act in an authoritative and decisive manner. Their ability to foster teamwork is also particularly relevant. Whilst they must develop a team culture across all levels of the directorate, their most important team relationship is with their directorate management team. Here they must trust in the ability of each of the management team and have the confidence to delegate decision-making to them. Staff interaction and satisfaction are also key indicators to a Clinical Director's efficiency and effectiveness. Both of these elements rely to some extent upon a Clinical Director's ability to manage interpersonal conflict. As each directorate contains a variety of departments and staff (often with competing demands), conflict can readily occur. The success of a Clinical Director can be measured by their ability to identify, prioritise and quickly resolve issues before they get out of hand.

The third dimension of efficient and effective clinical directorship that is proposed by the emergent model centres on the intra- and interpersonal skills. Intrapersonal skills include a Clinical Director's commitment to the management role and participation in organisational direction. Interpersonal skills include communication and tolerance.

Commitment to both the role and the organisation are important contributors to a Clinical Director's efficiency and effectiveness. Often having a considerable clinical workload, managerial commitment is best illustrated through a Clinical Director's dedication, their level of involvement and the amount of time they allocate to the role. Participation by way of an affirmative contribution to the strategic direction of the organisation is also considered an important element of successful directorship.

Interpersonal skills that are important to a Clinical Director's success include effective communication and tolerance of others.

Communication skills include the ability to listen well, interact constantly and communicate effectively. The emergent model suggests that communication skills must be applied at all levels of the organisation. Tolerance by way of an appreciation of other's viewpoints promotes effectiveness through teamwork. Competencies in both of these areas are important contributors to a Clinical Director's decision-making process.

6.5   Domain Knowledge and Skills

The managerial and professional roles of Clinical Directors symbolise the adoption of both New Public Management ideology and the current management philosophy on managing professionals (Thorne, 2000). Faced with these changing paradigms, the transition from clinician to manager is a difficult one for doctors to reconcile (Leggat et al, 2006). Doctors are results-oriented people who are very quickly frustrated by bureaucracy (Petasnick, 2007). Being caught between the management and medical cultures, Clinical Directors have had to learn to balance complex and often competing objectives (Thorne, 2000).

The hope, with the implementation of clinical directorates, has been that doctors are able to bring unique clinical insights to hospital management. Their knowledge of clinical medicine, diagnosis and treatment, how their peers' think, the politics of healthcare and the environment in which they work are critical elements that are nearly impossible for non-clinical managers to bring to hospital management.

The importance of this contextually unique domain knowledge and the associated skills cannot be underestimated. The impact of a Clinical Director's clinical experience, influence on peers, political expertise and knowledge of the health environment will each be discussed in turn.

6.5.1 Clinical Experience

The emergent model proposes that a successful Clinical Director must be a current and experienced medical practitioner. Both of these elements allow a Clinical Director to bring a credible level of clinical expertise to their decisions. Both Kusy et al (1995) and Mitka (1994) believe clinical competency and an understanding of current clinical issues are crucial components in building trust and credibility. This is particularly important in dealing with medical colleagues, as according to the data, a doctor will tend to accept the decisions made by a practicing clinician over those made by others. As one respondent noted:

> *"If they know that the person saying no to them is also a clinician currently practicing in the same organisation, then they're much more likely to accept it as being a valid and rational decision."*

The study's data highlight the valuable contribution to change that can be brought about by the inclusion of a doctor in the decision-making process. As put by one Clinical Director:

> *"Clinicians are the people who understand what the clinical process actually is and how they can change it."*

However, the validity of a doctor's contribution is related to their currency of practice. Shortland and Gatrell (2005:508) use the term "broad scanning" to describe the process of keeping abreast of current healthcare issues. They believe that this will not only help with the decision-making process, but also will enhance a Clinical Director's credibility with their medical colleagues.

The data also suggest that by bringing a clinical focus to managerial decision-making, a Clinical Director is in a better position than a corporate manager to influence change. It was perceived that by understanding the clinical process, they could more easily see how management decisions will impact upon the quality of care. As one Clinical Director pointed out:

> *"…clinical staff understand the concept of clinical excellence [and] high quality healthcare services at a level where they are working*

with patients. A lot of corporate directors barely see a patient from
day to day."

Bearing this in mind, a Clinical Director often has to struggle with the internal conflict that their Hippocratic oath evokes. One respondent commented that:

"... the fact that they're doctors does hinder them, because at the end
of the day...they're always going to have their patients' best interests
in mind and unfortunately, that's not always in the best interest of the
directorate."

As demonstrated by the preceding quote, trying to balance obligations to the directorate against a patient's best interest can prove to be a daunting task. The data suggest that this dichotomy may be as a consequence of the medical training process. It was suggested that throughout medical school, doctors are encouraged to focus on individual relationships with their patients rather than broader organisational issues. The ethos taught, is that diagnosis and treatment must take precedence over all else. One respondent summed up their impression of medical education's focus as being:

"whatever the patient needs – the patient gets."

Despite the possibility that organisational goals may be compromised, the data indicated that having some clinicians with a total patient focus is good for the organisation. One Nurse Manager termed it the organisation's 'conscience'. It was something that she believed should not be lost.

Having a quality focus was seen as a way to mitigate the dilemma between individual patient care and achieving financial goals. Practicing clinical governance and ensuring that management decisions are supported by sound clinical evidence were considered by respondents to be important contributors to aligning healthcare quality with financial goals. One Business Manager believed that:

"...the ideal would be for everyone to operate on evidence-based
practice – ideally to a gold standard...Nothing gets implemented
unless there's ... solid evidence."

In the Western Australian context, it was perceived that some Clinical Directors were ineffective in their roles when judged on their contribution to quality healthcare. One Nurse Manager commented that:

"...some Clinical Directors are in the positions, but [are] not really performing...and you can see that because evidence-based practice and the quality of work coming out of some areas [is] just not up to standard."

The study's data suggest that the adoption of quality indicators such as benchmarking, key performance indicators and accreditation are ways in which a Clinical Director can be shown to be effective. As one Clinical Director noted:

"We've also made comparisons across a number of indicators with other like organisations across Australia as part of [a] benchmarking exercise ..."

Research by Guven-Uslu (2006) made a similar finding. He discovered that although managers and doctors tend to diverge in their orientations to healthcare delivery (cost versus quality), managers highly prize the contribution to service improvements that Clinical Directors can make by way of evidence-based practices and benchmarking.

6.5.2   Peer Influence

Trying to influence the thinking of their medical colleagues is a task that Clinical Directors often find difficult (Willcocks, 1994a). The emergent model proposes that the degree to which a Clinical Director can influence their medical colleagues is dependent upon how they manage the personalities of some of their peers, the level of credibility and respect they command, the confidence with which they deal with their peers and how assertive they are in enforcing decisions. As one Clinical Director commented:

"doctors are egotistical bastards ... and they can probably get away with it."

Making sometimes unpopular, organisationally-focussed decisions that go against their colleagues' interests can be confronting to a Clinical Director. The answer as to why it is so confrontational may simply be that doctors are a difficult group to manage. One Clinical Director proposed:

> *"… you're dealing with very intelligent people who are probably working very hard under a significant amount of pressure who probably have a natural dislike of authority and control and probably hate bureaucrats."*

Managing professionals is a difficult task. Brown and Mayer (1996) sum up the relationship by saying that doctors tend to be unco-operative, self-directed, autonomous and resistant to change. Managing medical colleagues, said one Clinical Director:

> *"…has been likened to herding cats."*

The study shows that performance management can prove to be difficult, as it is not considered to be particularly important among doctors. As revealed by the data:

> *"… when you performance manage doctors and assess them, you're doing it against criteria that don't involve their general clinical skills. It gets very hard. It's very difficult. Medical staff are very powerful. You run into problems trying to discipline them or curtail them."*

Disken et al (1990) suggest that it is the tenet of clinical freedom that places substantial limitations on a Clinical Director's authority over their medical colleagues. Doctors are in unique positions of authority and status in hospitals due to their clinical freedom. Being legally responsible for the welfare of those under their care, doctors are often able to use their clinical autonomy to direct resources without challenge (Bailey, 1995). Boyce (1994) agrees. She proposes that the special standing doctors have in hospitals often subverts what is intended to be a managerial

subordinate into a colleague. Clinical Directors end up with little management authority over other doctors. In such cases, Boyce (1994) believes that the managerial norms of accountability are hard to apply. Provided treatment is given within the limits of the law, ethics, contracts, professional standards and resources, a Clinical Director would find it almost impossible to instruct their colleagues on matters of patient care. As a consequence, Clinical Directors find it extremely difficult to:

- Commit peers to resource or workload agreements without their consent.
- Discipline or sanction peers whose behaviour is outside agreed limits; or
- Over-ride the clinical judgement of medical colleagues.

(Disken et al, 1990:17)

Although not revealed by the data, Willcocks (1998) describes how the level of peer support can be strongly influenced by the age of the peer and the medical discipline being managed. Willcocks (1998:171) found:

"… the older doctors were more likely to be cynics or be resistant to change because they had been trained in a different era, and had grown up with a different set of values and assumptions about the nature of professional work, vis-à-vis management."

With respect to medical disciplines, Willcocks (1998) found that acute specialties such as Emergency and Intensive Care Medicine tend to display cynicism over the introduction of clinical management. Perceiving it as a possible mechanism for control, the doctors in these specialties tend to resist by upholding the traditions of clinical freedom and autonomy.

In contrast, specialties such as Radiology and Laboratory Medicine tend to embrace the concept of clinical management. Being service-orientated specialties with a background of structured corporate management, the doctors in these disciplines are able to quickly adapt to clinical directorship (Willcocks, 1998).

In addition to dealing with challenging and forceful personalities, a Clinical Director can be faced with the difficult task of directing rather than representing their peers (Capewell, 1992). For example, they may be faced with complex problems such as addressing professional performance or standards of care (Fitzgerald, 1994). To appropriately deal with such issues, a Clinical Director must command an appropriate level of credibility and respect from their peers. As the data revealed:

> *"If they're highly respected as a Physician, then their peers are much more likely to take on board their recommendations or assertions."*

Much of the data also indicated that to achieve success, a Clinical Director should be a leader in their field, possess high clinical standards and have broad respect across all specialties. As one Business Manager observed:

> *"...if your standard of clinical practice is not highly regarded amongst your peers, its very hard to try and convince them that they should alter their practice..."*

Disken et al (1990) and Kusy et al (1995) agree that the broad support and confidence of their peers is important to a Clinical Director. Without this, their peers will be hard pressed to believe that their views will be represented fairly and honestly (Capewell, 1992; Bernstein, 1993; Dawson et al, 1995).

According to Reinertsen (1998), a Clinical Director must use their credibility and respect to balance the concerns of their medical colleagues with the needs of the organisation. When looking at 'big picture' issues, achieving consensus among peers is essential. However, in taking an organisational-wide view, the interests of their peers may not necessarily be supported. Without the necessary credibility and respect, their medical colleagues may perceive themselves as having been 'sold out' (Reinertsen, 1998). The comments of one Chief Executive highlight the perception that peer respect plays an important role in collegial influence:

> *"I'm looking for someone who has the respect and ability to work with clinical peers to form part of a medical executive and advise me on medical issues..."*

The study revealed that the credibility and respect of a Clinical Director should not just be limited to the opinions of medical colleagues, but rather, they should be widely held. For example, the data revealed that:

> *"...if they have credibility with the public, they actually bring credibility to the health system."*

From an organisational-wide perspective, Clancy (2002:25) comments:

> "Regardless of background, service-line directors must gain credibility among administrative, medical and clinical staff to build consensus on key issues and succeed in their role."

The data revealed that the Clinical Director who commands credibility and respect should be sufficiently confident and assertive to confront their peers and argue their position on issues. Such action, however, can be particularly difficult for a Clinical Director when their medical colleagues disagree with policies or remain determinately independent (Stroobant, 1995). As one Chief Executive commented:

> *"...when they don't deliver what their colleagues want...their colleagues start to question where their loyalties of focus lies..."*

In such situations a Clinical Director can feel vulnerable in making decisions for fear of offending their peers. The data revealed that:

> *"...they need to be seen ... from the hospital management, to be pulling their peers into line and on the other side, the peers were hoping that they'd be able to get change to their benefit. I guess they were sort of caught in the middle, trying to do the right thing by everyone."*

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Dopson (1994) and Fitzgerald (1994) both believe that when faced with this predicament, Clinical Directors can become concerned about alienating their peers. Sometimes, open hostility can occur that undermines clinical relationships. Fitzgerald (1994:41) describes that:

> "While many clinical managers experience support from colleagues and managers, there are some who see themselves as separated and on occasions, isolated from clinical colleagues."

Although not highlighted by this study, Dawson et al (1995) point out that the difficulties in managing medical colleagues can often be exacerbated when a Clinical Director knows that they have been appointed to be least likely to cause trouble (Dawson et al, 1995). Alternatively, and just as worrying from a peer management perspective, they may be a political appointment. In other words, they were simply put into the position to block 'inappropriate candidates' from selection (Thorne, 2000:329).

Bernstein (1993) comments that over time, the trend in the United Kingdom has seen many Clinical Directors be either conscripts or the only volunteers for the job. Bernstein (1993) points out that such a basis for appointment can see medical colleagues initially viewing their Clinical Directors with a fair degree of scepticism and suspicion. In such cases, suggests Bernstein (1993), the respect earned from past clinical achievements often has to be re-earned in the management role.

The appointment process for Clinical Directors in Western Australian teaching hospitals follows standard public sector recruitment practices (Royal Perth Hospital, 1995a). However, based on the researcher's experience, there is a paucity of competition for Clinical Director positions. It is therefore conceivable that many past and current appointments are the result of a solitary and possibly persuaded application.

The data suggest that in the Western Australian experience, Chief Executives would prefer competitive selection in order to avoid representative, ineffectual or political appointments. As one Chief Executive commented:

> *"They have to be prepared to stand up and actually contradict their colleagues at times."*

Representative management is also undesirable. As Reinertsen (1998) points out, being a representative of a specialist group can often result in peers being shielded from change when it is particularly needed. The best guide to follow when faced with having to go against the wishes of medical colleagues, suggests Reinertsen (1998), is to always put the interests of the patient first, irrespective of who takes offence.

Clinical Directors therefore find themselves treading very warily when it comes to managing their peers. At the forefront of their thinking is the concern that after a managerial role, re-entry into a full-time clinical position can be made difficult. As one Nurse Manager pointed out:

> *"... [as] they do their job for only three years and then ... go back and work with their colleagues, there's a reluctance to performance manage..."*

Those who have had to make tough managerial decisions in the past can find themselves in the unenviable position of being alienated from their medical colleagues (Mark, 1994).

All in all, the challenge of influencing peer behaviour is highly charged with disadvantages. The perception held by doctors - that management is of a secondary importance, is engrained deeply in medical culture. It follows that those doctors who take up a management position can potentially risk a loss of clinical respect and visibility (Llewellyn, 2001). Llewellyn (2001) suggests that in the eyes of their peers, to be involved in management … is to be inferior.

6.5.3 Political Expertise

Clinical directorates can be considered to be a management model that facilitates the use of political endeavour to achieve organisational goals. In line with the needs for managing professionals, it encourages the spirit of negotiation by facilitating discussion between management and the various medical specialties found within a hospital. The emergent model proposes that a Clinical Director should bring to the management role a level of political astuteness, borne from the ability to look at health management issues from a clinical perspective. As one Nurse Manager pointed out:

> *"...the other attribute they bring ... to the table is politics. I believe [that] if we didn't have them sitting around the table in our model, we'd be missing [an] opportunity from a political level. They bring political astuteness and [an] ability to ... tackle issues [at] a different level."*

The data suggest that Clinical Directors must be flexible in their attitudes and that political game playing is very important in achieving success. As proposed by one respondent:

> *"...they must know how to work the system."*

According to the data, skilful negotiation plays an important role in 'working the system'. Such a skill requires a strong political base. From this base, Clinical Directors should be able to negotiate and persuade (Kusy et al, 1995). As suggested by one Business Manager:

> *"... you need to be able to negotiate and to lead people to areas where they don't necessarily want to go."*

Braithwaite (2004:255) made a similar finding. His research revealed that:

> "… management activity in clinical units is heavily social, centres on discourse, persuasion and negotiation, and involves working with and

influencing individuals and groups, and in turn being lobbied and influenced. To be effective requires well-developed political and social skills and verbal ability and the capacity to cope with multiple issues, tasks, responsibilities and requirements within a richly textured, ambiguous, challenging and deceptive habitat."

The effective Clinical Director must also be able to recognise and appreciate that there will exist a wide range of interests within the organisation. According to one Clinical Director, one must have:

"… an ability to broker arrangements between various units in terms of competing demands."

To achieve this, Willcocks (1994b:31) proposes that:

"The effective Clinical Director should be able to identify and understand individual interests and perceptions, build upon informal alliances, and utilize symbols to shape the reality of organizational life."

It is also important that a Clinical Director is not simply a representative of their directorate. They must be able to look past inter- and intra-directorate rivalry and use their political abilities to achieve broad organisational goals. As one Business Manager remarked:

"[Clinical Directors] have to have some very good negotiating skills. …at times, we all think that the area we have is the best and that we should all have priority."

Given that each group within a hospital tends to think that their cause has priority, a Clinical Director needs to have a familiarity with factional needs. From that familiarity, they can then build coalitions with other groups in order to achieve integrated solutions (Kusy et al, 1995).

The data indicates that the difficulties of management can be exacerbated by the presence of elitist cultures and powerful individuals within the medical profession. As one Nurse Manager pointed out:

> *"…they are very powerful, and in this organisation the medical staff wield huge amounts of power."*

Willcocks (1998) found that such groups are likely to oppose clinical management. The reason, he suggests, is that they tend to pursue their own political interests at the expense of corporate goals. Under this scenario, appropriate peer management becomes an important component in a Clinical Director's success. As one Department Head commented:

> *"I think the business of running these large institutions is not fiscal or financial. I think it's to do with people and how you control people's egos. Control is not the right word … manage their egos."*

The data suggest that given the political power that can be exerted by their medical colleagues, Clinical Directors are caught in the dilemma between clinical representation and clinical leadership. As proposed by one Chief Executive:

> *"They have to be prepared to stand up and actually contradict their colleagues at times. One of the problems, especially in the clinical field to a large degree, is of people's unwillingness to stand up and contradict their own colleagues, even though it's better for the system."*

Reinertsen (1998) agrees. He believes that the hardest challenge for a Clinical Director would be to choose between looking out for those who have elected them or the broader interest of the organisation. In these circumstances, the data proposes that a Clinical Director should make decisions that are in the best interest of the organisation and then be prepared to defend their stance to colleagues:

> *"You have to make decisions and stick to those decisions. Let your colleagues know why those decisions have been made (whether*

they're popular or not) and actually pull people together into a team

to see what the aim of the organisation is."

Sang (1993:354) makes a similar point:

> "Clinical Directors may need to subordinate the interests of their own
> specialty in order to meet an agreed unit priority and then defend this
> decision against challenges from their own consultant colleagues."

6.5.4   Knowledge of the Health Environment

The hospital domain also dictates what skills a Clinical Director needs in order to be efficient and effective. In particular, they need to have a sound knowledge of the environment in which they manage. This includes an understanding of elements such as the broader health system, the public sector, the hospital and the components of their clinical directorate. The Western Australian experience suggest that such an environment is one in which funding is limited, demand is great and politics are rife (Deloitte Ross Tohmatsu, 1991). When viewed with a 'clinical mentality' these pressures can, to some extent, be disregarded by doctors. However, when charged with management responsibility, they must all be carefully considered.

Bureaucracy within the public health administrative systems is an element of management that many doctors find frustrating (Petasnick, 2007). Yet according to the data, a broad understanding of the public health system is important. As one Clinical Director pointed out:

> *"One of the real issues for me and what I think is important for*
> *Clinical Directors, is that they need to have to come to understand*
> *the sort of broad operations of the public health system and how it*
> *influences the way we have to undertake the administrative role."*

Importantly, the study showed that elements of the health system such as policy, funding, politics and public sector standards require specific attention and understanding.

The data suggest that to many doctors these elements are quite foreign. A possible reason is their grounding in the private sector or their management of private practices. For example, one Business Manager commented that:

> *"… clinicians need to be aware of the public process and not work on the mentality of the private sector where you can just go out and buy that or we can just hire … or just sack that person. There are requirements in … public sector standards…"*

Research by Willcocks (1995) made a similar finding. He found that Clinical Directors considered exposure to public sector management to be an important contributor to their effectiveness. Past experience in management or administration, committee representation and external business involvement were all thought to provide a good backdrop to their role as Clinical Directors.

The emergent model suggests that it is also important for a Clinical Director to understand the workings of their organisation in general and more specifically, the elements of their directorate. As commented by one Nurse Manager:

> *"…there are some good medical clinicians out there who are good managers and good leaders, but a lot of them aren't because they don't really know how the organisation works…"*

In an organisation as complex as a hospital, there are numerous and varying systems, functions, issues, specialties and staff that need to be recognised and understood. Such knowledge can be gained by a doctor having worked in the organisation for a considerable period of time. An advantage of a long-term association, according to the data, is to know who the key players are within an organisation and how to deal with them. The study also suggests that a long-term association can bring with it advantages of a corporate memory and cultural history. One Nurse Manager describes the attributes of a good Clinical Director as being one who:

"… has been in the hospital for a long time, who people believe [has] a good understanding of patient care commitment, [a] good understanding of issues…"

In contrast to the data, Simpson (1994) disagrees with long-term doctors being appointed to clinical directorships. She believes that the tradition of senior doctors tending to stay in the same institution for many years (if not their entire career) limits their effectiveness when taking on a management role. Having little experience of other management cultures and a limited understanding of change, she argues, are both inhibitors to success.

6.6   Domain Characteristics and Development Requirements

The preceding section discusses specific domain skills (clinical experience, peer influence, political expertise and environment knowledge) that are perceived to make a Clinical Director efficient and effective in their role. The following figure summarises that discussion by highlighting the domain characteristics that Clinical Directors are thought to bring to a devolved management environment as well as the development needs that are perceived to promote success in their roles.

Domain Skills

ENVIRONMENT ISSUES

Funding issues Internal and external politics Bureaucracy Public sector requirements
Community expectations Population needs Peer pressures Difficult personalities

Clinical Attributes	**Development Needs**

Clinical Experience

Clinical Attributes	Development Needs
Current clinical knowledge	Separating clinical and management roles
Clinical input into management decisions	Combining clinical and corporate outcomes through evidence based medicine
A patient focus	A corporate management perspective
Quality and safety through corporate governance	Developing clinical and corporate performance indicators

Peer Influence

Clinical Attributes	Development Needs
Collegial respect and credibility	The confidence to contradict peers
Peer rapport and influence	Decisiveness, resolve and assertiveness in decision-making
Community and patient respect	Dealing with strong, complex and intelligent personalities
Ability to recognise the clinical implications of management decisions	Communicating bad news
Ability to recognise unsustainable arguments through clinical knowledge	Balancing peer requests with organisational goals
Diplomacy in dealing with peers	Performance managing peers

Political Expertise

Clinical Attributes	Development Needs
Understand and influence of internal politics	Enhancing communication and negotiation skills
Facilitation of discussion through respect and clinical knowledge	Recognising the competing needs of all clinical disciplines

Environment Knowledge

Clinical Attributes	Development Needs
Understanding of healthcare industry pressures	Gaining knowledge of the health industry, external politics and funding issues
Corporate and cultural history of the organisation	Understanding public sector processes, policies and standards
Knowledge of key personnel within the organisation	Developing an operational knowledge of all aspects of the organisation

Figure 6.4   Domain Characteristics and Development Requirements

6.7 Business Skills

For many doctors, the unfamiliarity of a management environment can make them feel inadequate. This study's data would suggest that without specific management skills, they <u>are</u> inadequate. As one Head of Department pointed out:

> *"Medical Practitioners who have moved into management roles without special management training have struggled in some cases because they tend not to have the people skills and general organisational skills that are required..."*

According to the emergent model, the clinical directorate domain dictates that Clinical Directors need to learn specific management skills in order to be efficient and effective. Those skills include financial management, strategic management and human resource management skills. Such skills can be learned through either formal management training or via informal means. Formal management training may be by way of in-house professional development, external programmes or university management courses. Informal learning could be by way of networking. According to Stroobant (1995), a Clinical Director can learn a considerable amount of useful information by interacting with Business Managers, Finance Directors and Senior Nurse Managers.

6.7.1 Financial Management Skills

The data suggest that sound financial management skills are important skills that need to be learned by Clinical Directors. Not only must they be fiscally responsible, but they must also understand the financial process in order to manage and prioritise resources efficiently. The study indicated that successful budget management in the face of decreasing resources could be considered to be a good indicator of Clinical Director efficiency.

Research by Llewellyn (2001) suggests that over time, Clinical Directors have developed a greater financial acumen than their predecessors. However, the data for

this study tends to suggest that the financial skills of Clinical Directors are somewhat wanting. As commented by Nurse Manager:

> *"… medical staff are not renowned for their financial ability."*

Although Stroobant (1995) believes that Clinical Directors are increasingly able to actively participate in budget formation, the Western Australian experience found that many Clinical Directors tend to rely on the directorate's Business Manager to provide detailed financial analysis. This reliance, however, is not ideal as a Clinical Director's clinical knowledge is significant in determining what are reasonable levels of expenditure, activity and output (Stroobant, 1995). One Clinical Director observed that:

> *"There is a tendency to leave the financial side to the Business Manager and I don't believe that's going to be acceptable in the future and some financial analysis is going to be pretty important because I think you're going to be increasingly financially accountable."*

With a greater financial understanding, Clinical Directors, are able to more easily challenge the financial agendas of managers (Llewellyn, 2001) and make finance work to achieve a clinical service of uniform quality (Stuart et al, 1995). Their improved financial expertise should allow them to influence financial aspects (such as budgets and cost allocations) as well as clinical activity (Llewellyn, 2001). However, such influence is entirely dependent upon an appropriate budget process. The Western Australian experience suggests that in the face of severe funding constraints, there is not enough funding to efficiently manage patients. One Clinical Director highlighted the issue by commenting:

> *"I think that [our] effectiveness of course is constrained by the resources that [we] are given and I do think that we have a major problem in that area. I'd be a lot more effective if I had more resources to utilise (financial resources predominately) and I see*

those financial resources in two areas. One is in terms of the hospital's recurrent budget (of keeping the process going) but also in its capital needs."

In addition, the budget process appears to offer little incentive to generate savings:

"Whatever saving we make is never returned to us, and that [is] a frustration."

In an environment of constraints and little incentive, the prospect of balancing a tight budget against pressing clinical needs poses quite an ethical dilemma for a Clinical Director. Should they be representing the organisation or the patient? Many respondents to this study believed that the needs of the hospital rather than individuals, departments or directorates should receive first priority:

"Efficiency is about setting priorities, working out what's not negotiable and has to be done and then balancing the rights of other people. You have to balance your resources where your needs are..."

However, the data suggest that when actually faced with this predicament, a Clinical Director will tend to put the patient's interests first:

"Do I sign the form and put my budget over? I don't hesitate."

6.7.2 Strategic Skills

Before embarking upon strategic development, a Clinical Director must have a clear understanding of their role and also of the level of authority that they have been delegated. One Nurse Manager observed that:

"It's all about authority. It's about having delegated authority to commit resources. It's about having been empowered to do your job.

It's about being trusted to do your job and it's about being able to be open and honest about where your limitations are. If you're able to do that and are supported in making decisions, then you'll do okay."

Both Willcocks (1992) and Fitzgerald (1994) suggest that Clinical Directors are often unclear about the precise nature of their role. This study made a similar finding. In discussing inhibitors to effectiveness, the experience of one Chief Executive was that:

"They all had different views about what was expected of them as a clinical leader or Director on Executive. ...to a large degree, people didn't understand their roles..."

A lack of role clarity, suggests Rice (2007), will frustrate the managerial effectiveness of doctors who take on management responsibilities. According to Lewis (2004:111), Clinical Directors often assume roles that are "ill-defined, inconsistent and ambiguous". Fitzgerald (1994) made similar findings. Not only did she find that doctors were assuming ill-defined roles, but she also found that doctors themselves were not being used effectively. These processes, according to Fitzgerald (1994), can lead to two highly undesirable outcomes. The first outcome is that management will fail to improve and in all likelihood, will deteriorate. The second is that competent and motivated doctors get discouraged and end up withdrawing from participating in management roles.

Corbridge (1995) believes that this lack of role clarity is a consequence of Clinical Directors' non-management grounding and therefore a misconception as to what differentiates operational from strategic issues. However, in this study, the major cause of frustration was lack of delegation and the existence of parallel management structures. One Clinical Director described how:

"Responsibility has never been devolved to the Clinical Directors. There were all these strings that were held on to and the parallel structure remains a problem."

Disken et al (1990) describe how in many cases, Clinical Directors are appointed without job descriptions and are simply expected to get on with the task of managing. Respondents in this study revealed similar experiences. One Clinical Director recounted his experience:

> *"...I was invited to meet [a member of the Executive] to discuss my responsibilities... There was not a single word of clarification as to what ... the hospital was expecting out of me."*

Thorne (2000) found in her research, that such experiences are a culture shock to those doctors who are new to corporate management. Facing prescribed performance indicators, managerial accountability and role ambiguity, patently highlighted to Thorne's respondents the difference between managing in the medical culture and managing in the managerial culture. Thorne (2000:330) found that exposure to the managerial culture reinforced respondents' views, that management was an "alien world" to Clinical Directors.

Willcocks (1995) suggests that role ambiguity, like that found in this study, can lead to conflict, anxiety and stress. However, he also points out that for the proactive doctor, it can offer the opportunity to engage in role making. In other words, they can create their own role and use the prospect to influence the expectations of others.

The question as to whether or not a Clinical Director's role should include both operational and strategic functions is a controversial one. Whilst some respondents believed that operational issues should be taken on advice:

> *"...they don't actually have to do it, because that's why they have Business Managers and Nurse Managers..."*

Other respondents believed that the understanding of operational issues such as financial management is important:

> *"There's a tendency to leave the financial side to the Business Manager. I don't believe that's going to be acceptable in the future and [that] some financial analysis is going to be pretty important,*

because I think you're going to be increasingly financially
accountable."

Fitzgerald (1994) questions whether conventional managerial tasks such as staff management, team management, representing, setting standards and monitoring performance are really the best use of a Clinical Director's time. Although they are important, a Clinical Director's role, according to Fitzgerald (1994) should be more strategic in nature. Fitzgerald (1994) feels that giving Clinical Directors operational tasks is simply a waste of the unique insights they have gained through their medical experience. She believes that their role should really be more strategic in nature. Being in charge of a major service, their primary role should be one of implementing change. Many in this study agreed that the primary role of a Clinical Director is to provide vision and direction. One Nurse Manager noted that effective Clinical Directors are:

"...the ones that have a broad vision of the state of health in general
and can step from the operational realities of the directorate [into]
the strategic requirements of the role..."

The Job Description Form of a Clinical Director included in Appendix 6 supports this notion. The tasks outlined in the statement of duties are for the most part, strategic in nature. Terms that are used include 'responsible for…', 'promotes and fosters…' and 'evaluate and enhance…'.

Kusy et al (1995) agree that the role of a Clinical Director should primarily be strategic. They believe that to be effective, Clinical Directors must be able to develop and articulate a vision for the future. This may involve aligning individual goals with those of the organisation and gaining commitment to achieve those goals. The data proposed that:

"...They have to have an overall view [of] where health is going and
where it has been, so that they can make reasonable decisions that

benefit the whole of the service rather than an individual department."

An effective Clinical Director, suggests Kusy et al (1995), is one who is able to get commitment by showing their team 'what's in it for them'. However, the data shows that in doing so, a Clinical Director must avoid exhibiting vested interests. As one respondent suggested:

"… they face challenges in remaining impartial because they have actually come from a clinical discipline. Invariably there's the perception that they're feathering their own nests."

The data suggest that the way to negate the temptation of vested interests is to be sympathetic to the needs of others. As one Clinical Director noted, an effective Clinical Director must be:

"…able to recognise that even though you think your area is important…someone might have a better case than you do and their need may be more urgent…"

Tolerance is therefore an important attribute. One Chief Executive expressed that when assessing a Clinical Director, he looks for:

"…a willingness to learn about working with people. [It's] about managing people, their expectations and difficulties, but managing in a way that makes sure there's a degree of harmony and common sense."

However, with past generations of doctors being taught to be the ultimate decision-maker, tolerance for other's opinions can be difficult. The data suggested that:

"Medically qualified people tend to be pretty much their own people and once they've set their sights [they] go for it hard without considering…all the other implications…"

Willcocks (1994b) believes that the effective Clinical Director is one who is able to determine the cognitive maps of their medical colleagues and subordinates, identify their basic assumptions, values and beliefs and then recognise and accept any differences.

Their innate intelligence should help in this process. Willcocks (1994b) suggests that Clinical Directors may not necessarily be able to reconcile the differences between the various groups, but they may be able to develop a framework from which they can work. From an operational perspective, Disken et al (1990:24) believe that:

> "Perhaps the most important prerequisite for effective clinical management is for doctors and managers to know more about and better understand each other's roles and responsibilities."

Part of this role involves understanding and learning how to manage change in the organisation suggests Stroobant (1995). Getting others to be committed and involved in change is part of the fundamental skill of managing people.

6.7.3   Human Resource Management Skills

To a number of respondents, human resource management is considered an important, albeit one of the more difficult aspects of devolved management, for a Clinical Director. The data suggest that they need particular insight into elements of human resource management such as staff utilisation, motivation and teamwork. Without such insight, achieving success can be limited. One Business Manager pointed out that:

> *"They need to have some background in human resource management. Knowing how to get the best utilisation out of staff, how to motivate staff, how to foster teamwork."*

Dawson et al (1995) suggest that from a human resource management perspective, a Clinical Director faces the challenges of securing and maintaining the support of their

medical colleagues as well as providing leadership and direction for their management team. Although the devolvement of human resource management allows the flexibility for a Clinical Director to tackle such challenges, the amount of time human resource management consumes and the difficult situations it creates can be limiting factors. As observed by one Nurse Manager:

> *"…they aren't given enough time to undertake the challenges and solve the issues that exist…"*

However, the human resource management ability of future clinical leaders looks promising, suggested one Head of Department:

> *"I think we're going to find a new/different breed of medical practitioner over the next 10-20 years coming into leadership roles. It will be the type of people who'll be able to manage other people pretty well – better than us I'd think."*

Whether it is leading medical colleagues, the management team or other members of the directorate, the data suggest that well-develop leadership skills are an important dimension of clinical directorship. As proposed by one Nurse Manager:

> *"… it's fine to be an outstanding doctor, but unless you actually know how to lead a team, there's no point in stepping into a Clinical Director role."*

By having effective clinical leaders, Rice (2007) believes that meaningful ties between clinical staff and management can be forged. Further advantages of strong clinician leadership include improvements in patient safety, better employee morale and expanded services (Rice, 2007). Reinertsen (1998) believes a Clinical Director must be an agent for change and that effective clinician leadership ultimately leads to improvements in healthcare quality and economics.

Clinician leadership is important in that it defines what the future of healthcare should look like and aligns those involved with that vision. One Clinical Director suggested that:

> *"…the requirements of a Clinical Director … I think [are] strategic thinking, development of strategic policy and development of innovative methods of delivering care."*

Clinical leadership inspires change to succeed, despite whatever obstacles are put in the way. According to Shortland and Gatrell (2005), leadership is more about accommodating uncertainty than removing it. They believe that a clinician leader looks at:

- Building and communicating a vision for the future.
- Developing and implementing strategies.
- Helping people to understand and share commitment to service development.
- Motivating and inspiring colleagues.

Shortland and Gatrell (2005:506)

To be a successful leader, Reinertsen (1998) believes that doctors must be a change agent, initiator, objectivist, risk taker and persuader. Importantly, the data suggest that an effective clinician leader must act with conviction. One Nurse Manager proposed that:

> *"You have to make decisions and stick to the decisions, let your colleagues know why those decisions have been made, whether they're popular or not."*

If a Clinical Director believes an idea to be good, but contrary to the opinion of their colleagues, they must be prepared to stand by their opinion for the overall benefit of the organisation (Reinertsen, 1998). The data suggest that with the Western Australian experience, this is not always the case in practice:

> *"… I think that sometimes they duck difficult issues and I think that that's probably because they come from quite diverse background[s]*

with diverse opinions and their own directorate's needs foremost in
their minds…"

Importantly, doctors must also be able to think outside their immediate area of responsibility. One Head of Department suggested that clinical leadership is about:

"…having appropriate vision for what things might be and how
things might be and [then] marrying that with community opinion
and political opinion."

The most valuable improvements, according to Reinertsen (1998:834), occur when a doctor is able to think "outside the box". Although this adds significantly to the complexity of a clinician leader's role, Reinertsen (1998) believes that lateral thinking and action produces the most meaningful change.

Unfortunately, the data suggest that the in the Western Australian experience, this does not always occur. As one respondent noted:

"They just focus on one small area. They don't see the people
outside and what they have to offer."

Teamwork is also important. According to the data, effectiveness is:

"…pivotal on the teamwork that occurs"

To be effective, Kusy et al (1995) believe that a Clinical Director should demonstrate a high regard for diversity of opinion and an ability to build consensus by bridging differences. Being a team-builder rather than an autocrat encourages others within the directorate to share a Clinical Director's vision (Kusy et al, 1995).

The difficulty in managing professionals is highlighted by the traditional medical culture of ultimate responsibility for individual patients. Such a culture, suggests Simpson (1994:1506) results in an organisation of "single players". Braithwaite and

Westbrook (2005) make a similar observation. They believe that the hierarchical tradition of 'doctor knows best' and the lack of team-oriented training in medical education can promote a culture of physician superiority. As one Head of Department described:

> *"My vintage of graduates were taught to make all the decisions by ourselves, so there was no hint of teamwork ever taking place."*

Kaissi (2005:167) describes doctors' poor team orientation and perceived superiority in terms of an "occupational community"; membership of which, is determined by qualification and registration. Kaissi (2005) suggests that members of this exclusive community are of the belief that their work is special and socially significant. In the workplace, they usually only socialise with other doctors and their point of reference is commonly the opinion of their peers. Significantly, doctors are protective of their community, having the power to determine who can be part of it through strict regulation, licensing and certification.

The challenge for a Clinical Director is to bring all of those individuals within the occupational community together into a cohesive team. According to Simpson (1994:1506):

> "A group of clinicians working effectively together on management issues is far more powerful than a single voice and can often bring about major change."

Other important dimensions that build a shared vision include listening, coaching, delegating and guiding (Kusy et al, 1995).

For a team builder, the art of delegation (particularly to their management team) is an essential skill to master. As illustrated by one Business Manager:

> *"He's very happy to delegate responsibility. He's not a control freak as long as we keep him informed about the progress of things and go to him with issues and problems."*

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Importantly, a Clinical Director must learn to balance delegating too much work (due to over-commitment) with passing on too little (due to mistrust) (Stroobant, 1995).

Self-awareness helps a Clinical Director to realise their shortcomings and acknowledge that they must rely on others to make up for the skills and abilities they lack. Knowing their strengths and limitations, suggests Shortland and Gatrell (2005), will identify what strengths to build on and what limitations need developing or accommodating (through delegation).

As the delegation of tasks will, for the most part, be to the directorate management team, it follows that one of the most important relationships a Clinical Director should foster, is the one with their management team. As one Business Manager recounted:

> *"Each of us had different skills and experience and he accepted those skills and experience. If there was a nursing issue, he would be looking [to] the Nurse Manager to provide him with advice. If it was a business issue to deal with finances, resources or putting up submissions, he would be looking [to] me to provide him with that advice and often as a team we would make the decision."*

Shortland and Gatrell (2005) believe that trust is a key ingredient in successful delegation. To devolve responsibility, suggests Shortland and Gatrell (2005), requires a fair degree of trust and confidence, however, the long-term benefits can be significant. They believe that giving each member of the directorate management team a sense of ownership of decisions and processes will have a beneficial effect upon individual effectiveness, morale and motivation - provided, of course, that they share a common purpose and vision.

The data suggest that a Clinical Director needs to have the confidence to delegate operational responsibility to their management team. In return they need to be fully informed of all directorate issues as they arise. As one Nurse Manager described:

> *"The Clinical Directors tended to see their management teams as their Executive and knew that they didn't need to be there. Things*

continued to run. Provided they were apprised of what was going on, it wasn't really an issue."

This study found that the relationship between a Clinical Director and their Nurse Manager was of particular importance. As most Clinical Directors are involved in their role on a part-time basis, they are often dependent upon the full-time presence of their Nurse Manager. As one Nurse Manager pointed out:

"The Clinical Director identifies his vision, sets it…, runs it past me [and] I [then] work with him. You see what [the vision] is, but I make it happen. I'm the enabler. He can't enable, only because he does two sessions per week and because he doesn't have the time to understand the system and to put it in [to action] … that becomes critical - to have my ability as an enabler and to make it move forward…"

The introduction of devolved management structures has seen Clinical Directors placed in the uncomfortable position of having to resolve conflict between departments, their medical colleagues and other staff within their directorate. One respondent noted that:

"They don't like conflict very much. When it comes to difficult issues with colleagues…[they] have a tendency (in my perception) to want to be liked, do all the nice things, but not take a fair but tough stand when it is necessary."

Faced with departments and clinicians that have competing needs and thoughts of self-importance, a successful Clinical Director must be able to clearly identify, prioritise and quickly resolve issues within their directorate. The principal requirement of his position suggested one Clinical Director was:

"Being able to problem solve when there [is] a problem. Dealing with interpersonal issues and how to handle day-to-day conflicts is important."

Dedicating sufficient time to the management of conflict is a vital ingredient in achieving directorate goals. As Braithwaite (2004:55) points out:

"… successful managers [tend] to spend more of their time on conflict resolution, peace making and socialising/politicking than their less successful counterparts."

Unfortunately, however, Balderson and MacFadyen (1994) suggest that many doctors lack skills in conflict management. Not dealing with an issue in a timely manner can paralyse a directorate. Hard decisions often need to be made, yet the data suggest that Clinical Directors aren't necessarily the ones who want to be seen to be making those decisions. One Business Manager commented that:

"We have had some very difficult clinical debates between competing specialties and these have still not been resolved due to the fact that at the end of the day, clinicians will never make hard and fast decisions where someone is going to lose out."

Given that a Clinical Director is involved in their role for only a limited amount of time each week, it must be acknowledged that it would be difficult for them to influence the attitudes, behaviour and performance of all of their directorate staff. Despite this, the data suggest that a Clinical Director is perceived to be effective if staff morale, recruitment and retention is high and corporate performance indicators such as absentee rates are low. As one Clinical Director noted:

"…you can judge [effectiveness] by people wanting to come and work here, [to] stay and not leave."

To generate a sense of job satisfaction among directorate staff, a Clinical Director needs to be engaging. For example, Kusy et al (1995) found that giving credit and recognition to those under their directorship is a significant contributor to staff enthusiasm and commitment.

6.8   Business Characteristics and Development Requirements

The preceding section discusses specific business skills (financial management, strategic management and human resource management) that are perceived to make a Clinical Director efficient and effective in their role.   The following figure summarises that discussion by highlighting the business characteristics that Clinical Directors are thought to bring to a devolved management environment as well as the development needs that are perceived by the respondents to promote success in their roles.

Business Skills

ENVIRONMENT ISSUES

Harsh Economic Setting   Funding Constraints   Unreal Expectations   Poor Budget Planning
Lack of Incentives and Rewards   Clinical Imperatives   Parallel Management Structures   Incomplete Devolvement

Clinical Attributes	Development Needs

Financial Management

Clinical Attributes	Development Needs
An innate weakness in the understanding of business and financial issues	Developing a basic understanding of finance
Knowledge of clinical issues	Interpreting and analysing financial reports
Communicating funding issues to medical colleagues	An organisational focus
Understanding clinical priorities	Justifying expenditure and service development through business planning

Strategic Management

Clinical Attributes	Development Needs
Knowledge of health issues	Appropriately delegated responsibility and authority
Specialty or directorate bias	Clarity of roles and responsibilities
Clinical direction to strategic vision	An organisational focus
Innovative methods for delivery of healthcare	Strategic development and business planning skills
Interest in contributing to the strategic process	Developing change management skills
Developing/initiating/improving clinical performance indicators	Understanding and managing corporate performance indicators

Human Resource Management

Clinical Attributes	Development Needs
Clinical leadership	Leading at the Executive level
Decisiveness in decision-making	An organisational rather than representational focus
Directorate team appreciation	Staff utilisation and motivational skills
Collaboration and delegate skills	Team building skills
Executive Leadership	Dealing with issues of personal conflict in an appropriate and timely manner
Staff interaction, interest and involvement	Knowledge of recruitment and retention practices

Figure 6.5   Business Characteristics and Development Requirements

6.9 Personal Attributes

According to the emergent model, the clinical directorate domain dictates that Clinical Directors need to develop intrapersonal (self-knowledge) skills and interpersonal (relational-context knowledge) skills in order to be efficient and effective.

6.9.1 Intrapersonal Skills

The data suggest that a successful Clinical Director needs to exhibit intrapersonal attributes of role commitment and participation.

6.9.1.1 Commitment and Participation

The data for this study revealed that a Clinical Director's commitment to both their role and the organisation are essential contributors to their success. Desire to contribute and enthusiasm play important parts in the efficiency and effectiveness of a devolved management model. Specifically, the data showed that a Clinical Director needs to be dedicated to their role, allocate sufficient time to be involved and active in the management of their directorate. As noted by one respondent:

> *"…they have to be enthusiastic about their role in administration."*

Disken et al (1990) propose that the successful implementation of a devolved management structure into a hospital requires two important preconditions – strong leadership from the Chief Executive and enthusiasm from the Clinical Directors. To bring about a change in organisational thinking, a Clinical Director must become a champion for the cause and take on the challenge of winning over collegial sceptics. The data, however, suggest that Clinical Directors sometimes find it difficult to reconcile those objectives. As one Business Manager pointed out:

> *"I think that sometimes they have a hard time equating the two parts*
> *of their job, saying no to other clinicians and at the same time*
> *striving for gold standards."*

Kusy et al (1995) believe that doctors who wish to be involved in management roles must carefully examine their motives. The data suggest that they must be passionate and enthusiastic about having a role in management. As expressed by one Clinical Director:

"I think if you are going to be good at it, you have to want to do it."

Being a very demanding role, they must be committed to make changes in the healthcare system and not simply be looking for a way to escape clinical practice. Stroobant (1995) believes that Clinical Directors need to be proactive in their role. They must be able to initiate processes, be creative and lead in decision-making.

The time available to perform the role of Clinical Director is limited in many cases. Most positions are of a part-time nature, with only two paid sessions per week allocated to the role. As a consequence, Clinical Directors face the difficulty of finding enough time to meet both their clinical and managerial responsibilities (Buchanan et al, 1997). One Clinical Director remarked:

"I think the problem has always been (and I think it still is) that if you're a clinician such as I am and you have a very substantial clinical load and you run a directorate that includes essentially four departments, it is pretty hard to get it all done."

In their research, Bruce and Hill (1994:56) found that:

"One of the single most important factors impinging upon the Clinical Directors was mounting pressure on their time. The Clinical Directors in the sample were without exception part-time managers, usually with a full or slightly reduced clinical load. Many Clinical Directors felt it necessary to maintain a substantial clinical load as a means of ensuring that they were to secure the trust of their colleagues and maintain and develop their expertise as doctors."

The data suggest that two sessions (seven hours) per week is insufficient for a Clinical Director to effectively discharge their role. Such limited time makes performing directorate duties and maintaining an organisational focus difficult. With many Clinical Directors being Visiting Medical Officers (VMOs), they spend only a portion of their working week in the hospital. Being divided between their private practices outside of the hospital and their clinical responsibilities within the hospital leaves little time for them to concentrate on their directorate roles. One Business Manager commented that:

> *"... it's an important role that they have and I think that most Clinical Directors in health probably only have two sessions to do that and that's not a lot of time to work internally within the directorate plus have a broad focus within the hospital."*

The data suggest that Clinical Directors find it difficult to sacrifice clinical time despite needing to allocate more time to the managerial component of their role. One Nurse Manager described how:

> *"...most clinicians do not appear to want to give up a large percentage of their clinical role."*

Ong (1998:205) proposed that a circumstance such as this could contribute to misunderstandings between medical and management agendas. Ong (1998) describes how for doctors in management, the currency of clinical commitment needs to be the equivalent of management commitment. One Clinical Director described how:

> *"...a lot of clinical people find it difficult to assign the necessary time and resource[s] to meeting some of their administrative roles. The call, so to speak, of the clinical area will always dominate."*

If doctors are only given one or two sessions (3.5 – 7 hours) per week to engage in management, Ong (1998) suggests that they would be drawn into believing that management is a less important task than their clinical commitment.

It was perceived by a number of the respondents that most Clinical Directors have a desire to maintain their full clinical workload. As observed by one Business Manager:

> "… first and foremost they're doctors and that's what they're here to do."

Interestingly, a number of respondents perceived that Clinical Directors' workloads were far too heavy and that a greater proportion of their time should be devoted to the managerial component of their role:

> "I think from a medical leadership point of view that the Clinical Directors have too much clinical contact. They really should have more [time] in the management role."

This finding confirms research performed by Llewellyn (2001). She discovered that the cohort of Clinical Directors she interviewed demonstrated a primary commitment to their clinical work at the expense of management time.

Such comments demonstrated that the balance between clinical and managerial workloads is extremely important. Without an appropriate amount of clinical exposure, clinical respect can be diminished.

Whilst Grebenschikoff (1997) believes that the need for clinician managers to see patients is a myth, research by Llewellyn (2001) suggests that the reason Clinical Directors devote more time to clinical responsibilities is to demonstrate to their colleagues that their real allegiance lies with clinical practice. Although the respondents to this study were not as specific, they did suggest that clinical currency and collegial esteem were important elements of successful directorship (see also

discussion on clinical experience §6.5.3 and peer influence §6.5.4). As an example, one Business Manager believed that:

> *"… anything that was achieved by [their] former Clinical Director was achieved on the basis of their reputation as an exceptional clinician."*

Dopson (1994) and Dawson et al (1995) consider other reasons why Clinical Directors may maintain their full clinical responsibilities. Whilst Dopson (1994) suggests that Clinical Directors often feel guilty about 'dumping' clinical work on their already overworked colleagues, Dawson et al (1995) believe that they become concerned over their professional credibility in terms currency of their clinical knowledge. The time spent managing, propose Dawson et al (1995), can limit the amount of professional development time available to a doctor.

Dawson et al (1995) also suggest that the time taken up with managing can impact upon the earning capacity of a doctor. For example, they found that Clinical Directors spend up to twenty hours per week performing the management role for which they are allocated seven hours. When considering how much money could be earned in the private sector during those hours, it soon becomes apparent that the opportunity cost of this time is significant.

Given the small amount of time allocated to directorate management, a successful Clinical Director must be able to manage their time efficiently. Without successful time management, a Clinical Director can become overwhelmed and inefficient. Low priority issues will tend to be dealt with first and the more difficult and sometimes important issues will be left to fester.

A doctor who decides to enter the management field must be prepared to commit time and energy to the role. They have to be very hard working and motivated. A number of respondents even suggested that Clinical Directors should be full time in their role:

> *"… we need to have Directors more engaged in directing…I mean full-time."*

LeTorneau and Curry (1998) suggest that those doctors whose primary motivating factor in entering management is unhappiness with their clinical role are doomed to failure. They believe that if doctors consider management is an easy stopover on the way to retirement and that the skills needed are simple and easy to obtain, they are sadly mistaken. Management is a time consuming and demanding activity and often leaves a doctor little time to pursue their clinical work, let alone teaching and research (Stroobant, 1995). As LeTorneau and Curry (1998:4) point out, a management career in times of significant change in the healthcare arena is not for "amateurs or the fainthearted".

Participation is an important aspect of clinical directorship. The data suggest that today's doctors are expressing a greater interest in organisational issues such as strategy and planning. They want to contribute to the decision-making process and play a part in the future direction of their hospitals. One Clinical Director felt that:

> "There's a sense now [of] the need to participate more vigorously…you have to stand up and deliver."

Importantly, it was believed that the fundamental reason a Clinical Director should be participating is for the betterment of the organisational rather than their directorate. Participation for the sake of self or collegial interest is detrimental to the organisation as a whole. As noted by one respondent, a Clinical Director must be:

> "…able to recognise that even though you think your area is important…someone might have a better case than you do and their need may be more urgent."

Stroobant (1995:129) believes that from an intrapersonal perspective, a Clinical Director must possess what he terms, "achievement drive". That is, the ability to manage and see projects through to their completion. The data suggests that the rewards for such drive can be satisfying:

> "We've been given several opportunities to take some big projects forward because we've been able to demonstrate some success previously."

Similarly, Kusy et al (1995) found that the determination to persist when challenged by obstacles is a dimension of successful directorship. However, the data would suggest that frustrations borne of the Western Australian context could test the persistence of Clinical Directors. One Business Manager postulated that:

> *"The health system is seen to be important and I think we'll get people who are committed (the people that we have now) staying with the system. If there is continual … frustration in the system, I think you'll find [that] [you'll] have less committed people … take over these positions."*

6.9.2   Interpersonal Skills

Interpersonal skills are primarily considered as collaborative skills. They deal with social relations (Viitala, 2005) and involve initiating, building and maintaining successful relationships over a period of time. In a hospital environment, collaboration can be with individual staff, across specialty groups or across directorates (Elmuti, 2004; Hogan, 2007). As expressed by one Chief Executive, in selecting a Clinical Director, he looks for a person who has:

> *"...a willingness to learn about working with people. [It's] about managing people, their expectations and difficulties, but managing in a way that makes sure there's a degree of harmony and common sense."*

Elmuti (2004:444) describes how interpersonal skills consist of four components:

1. Disposition to oneself in place of another persons.
2. Skills to correctly anticipate another person's expectations.
3. Skills to incorporate those expectations in one's subsequent behaviour.
4. Self-control to stay focussed on the other person's expectations.

Interpersonal skill development is important to the Clinical Director as the introduction of devolved management structures has given staff the opportunity for more interaction with their Executive. One Clinical Director described how:

> *"They need to feel that they can always come and knock on the door and either speak with you or find you or find out where you are so that they can talk with you."*

With increased interaction, a Clinical Director needs to build and maintain relationships across all levels of the organisation, both inside and outside of their directorate. Viitala (2005) believes that this involves understanding people and their behaviour, being skilled in social judgement, communicating and interacting with others, motivating and handling conflict.

The data suggest that a successful Clinical Director not only needs to be intelligent and analytical, but should also exhibit a competency in communication.

6.9.2.1 Communication

Much of the management literature suggests that communication is a key management activity (Willcocks, 1995). The data for this study make a similar observation. As one Business Manager noted:

> *"…communication skills are absolutely vital…"*

According to Willcocks (1995), when first appointed, Clinical Directors spend a considerable amount of time communicating with others. Such time would be spent defining their role, determining the expectations of others, building teams, communicating work requirements as well as clarifying values and beliefs.

The data support the notion that communication skills across all levels of the organisation are essential for successful clinical directorship. Clinical Directors need

to be able to facilitate discussion among those with and without clinical backgrounds. For example, whilst one respondent noted that Clinical Directors need:

> *"…the ability to communicate very clearly to their peers at a very high level"*

Another suggested:

> *"…they need to be able to put their case forward in different forms … they [could] be talking to people without a clinical background…"*

Listening is also important. An effective Clinical Director must be prepared to listen and take an interest in the requirements and suggestions of all those across the organisation. As one Nurse Manager noted, a Clinical Director needs:

> *"…to be able to listen and take an interest in the goings on."*

The data suggest that communication must be open and honest and flow in both directions. The successful Clinical Director is one who is able pass information up and down the hierarchy through open channels of communication. One respondent observed how their Clinical Director:

> *"…has been a very open communicator. He's taken [issues to] the hospital executive, took from them and fed back. He's kept good lines of communication open."*

According to Bernstein (1993), effective communication is the best way to reduce conflict and annul resistance to management initiatives (Bernstein, 1993). Capewell (1992:443) suggests:

> "An effective director prefers talking to writing, meeting to telephoning. He must be involved and committed, an effective communicator inside and outside the directorate."

Part of a successful communication process involves convincing their colleagues that under a devolved management model, clinical freedom for the individual practitioner remains intact. By guaranteeing the essence of autonomy they should be able to build confidence among their medical colleagues and persuade them that devolved management does work to improve clinical services (Disken et al, 1990).

However, the data would suggest that a Clinical Director would have difficulty in communicating such a message. One Clinical Director commented that:

> *"doctors don't like to deliver bad news to patients and we aren't really that good at delivering bad news to our colleagues."*

6.10 Personal Attributes and Development Requirements

The preceding section discusses the personal attributes (commitment, participation, communication and tolerance) that are perceived to make a Clinical Director efficient and effective in their role. As with the two preceding sections, the following figure summarises that discussion by highlighting the characteristics that Clinical Directors are thought to bring to a devolved management environment as well as the development needs that are perceived to promote success in their roles.

Personal Attributes

ENVIRONMENT ISSUES

Professional subordinates   Varying professions   Intelligent and strong personalities   Interpersonal conflict
Lack of time   Collegial expectations of representation   Time consuming role

Clinical Attributes	Development Needs
Commitment & Participation	
A willingness to dedicate time to management role	Allocation of sufficient time to the management role
An enthusiasm to take on new challenges	Reduction in clinical workload and demands
A desire for involvement in corporate decision-making	An organisational rather than vested reason for participation
Communication	
Listening skills	Relationship development at all levels of the organisation
Effective communication discussion facilitation	Delivering "bad" news

Figure 6.6   Personal Attributes and Development Requirements

6.11 Dimensions of Competence (A Comparative Model)

Successful clinical directorship requires competency across a number of important dimensions.   In their research, Gatrell and White (1996:34) divided key characteristics of competent directorship into five broad categories they termed "clusters of capability". The categories they developed were:

- Contextual Awareness

- Self-management

- Strategic Thinking

- Functional and Operational Skills and Knowledge

- Interpersonal and Team Skills and,

The following figure illustrates how each of Gatrell and White's categories relate to dimensions of the emergent CD2E model.

Contextual Awareness	Domain Knowledge and Skills
Self-management	
Strategic Thinking	Business Skills
Functional and Operational Skills & Knowledge	
Interpersonal and Team Skills	Personal Attributes
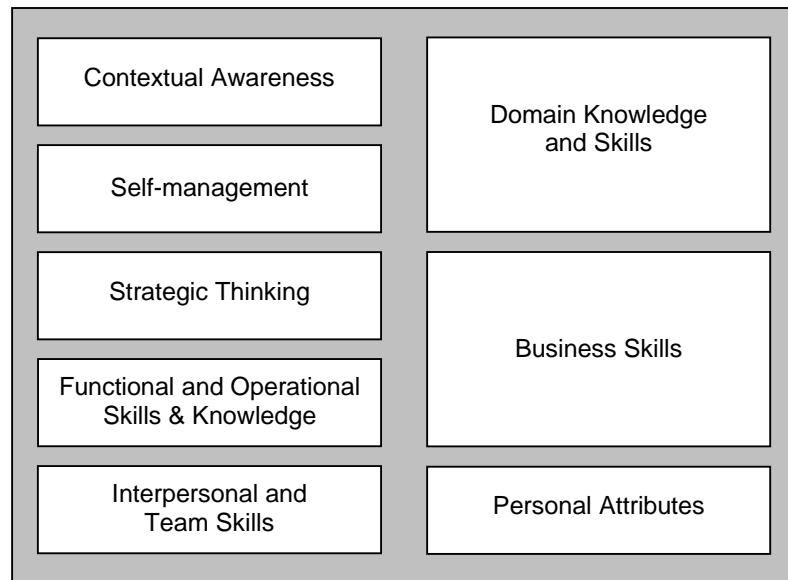
Figure 6.7   A Comparative Model

The first category, 'Contextual Awareness', could be considered to be an element of the dimension of 'Domain Knowledge and Skills' that are described in the emergent CD2E model. Gatrell and White (1996) describe how contextual awareness involves

understanding and operating effectively at all levels of the health service. As with the emergent model's element of environment knowledge, contextual awareness includes knowledge of issues such as government health strategy, the funder / purchaser / provider concept, organisational roles and directorate processes.

The next category, 'Self-management Skills', relates to those skills that the doctor develops in order to effectively perform their role. Gatrell and White (1996) list examples of those skills as learning from experience, managing their professional reputation, implementing difficult non-clinical decisions, acting independently, using initiative, managing time effectively, dealing with uncertainty, being self aware and presenting well. Many of these components are categorised in the dimension of 'Domain Knowledge and Skills' in the emergent CD2E model as elements of political expertise and clinical experience.

The next two categories of Gatrell and White's model are 'Strategic Thinking' and 'Functional and Operational Skills and Knowledge'. These categories closely relate to the dimension of 'Business Skills' described by the emergent CD2E model.

The category of 'Strategic Thinking', for example, involves understanding and implementing strategic processes. Similar to the emergent CD2E model, it may include the development of a vision and long-term strategies, the setting of organisational goals and the linking of a strategic imperative to daily activities (Gatrell and White, 1996). 'Functional Knowledge of Operational Activities and Processes' involves an understanding of the daily operations of the clinical directorate. Like many elements of CD2E's financial, strategic and human resource management components, this category in Gatrell and White's model can include the management of human resources, finance, information systems, business activity and quality systems (Gatrell and White, 1996).

The final category of Gatrell and White's model is 'Interpersonal and Team Skills'. This category corresponds to the dimension of 'Personal Attributes' described in the emergent CD2E model. It involves many communication and relationship activities, with examples being presenting, chairing, counselling, mentoring, delegation, conflict resolution, discipline and goal setting (Gatrell and White, 1996).

6.12 Utilising the CD2E Model

One of the problems most frequently cited with regard to directorate implementation is the lack of management training for doctors (Lazarevic, 1994). Sang (1993) makes a similar observation. He believes that doctors are often asked to take on the role of Clinical Director with little or no management training and that more needs to be done in this area. Many doctors, according to Shortland and Gatrell (2005), are of the same opinion, believing that they are somewhat out of their depth and poorly prepared to take on Clinical Director duties.

Before embarking on a managerial role, Simpson (1994) suggests that a doctor must decide for themself how much time and energy they are willing to invest in both their role and their management education in order to make a meaningful contribution to the organisation. They must make an honest assessment of their personal strengths and weaknesses so that they can build on their strengths and determine what areas can be developed with the right training (Shortland and Gatrell, 2005).

The CD2E model helps to identify the perceived skills and attributes necessary for efficient and effective clinical directorship. The model not only provides a framework by which existing Clinical Directors can compare their personal skills and attributes, but it can also be used in the development of appropriately focussed training and development programmes. By offering a framework that will assist in recognising the skills and attributes for successful clinical directorship, the model may also help healthcare organisations in identifying and recruiting suitable doctors for executive responsibility.

6.13 Chapter Summary

Over the past two decades, the ideology of New Public Management has substantially impacted upon the way hospitals are managed. Structural changes have meant that more of the responsibility for managing hospitals has been devolved to doctors. In addition to their clinical responsibilities, they have also been charged with the difficult tasks of driving efficiencies and promoting greater effectiveness in their management roles.

The concepts of efficiency and effectiveness are often used to measure a manager's performance. The same measures apply to doctors in management. Managerial efficiency is about 'doing things right', whilst managerial effectiveness is about 'doing the right things'. In the hospital setting, a Clinical Director's efficiency is often judged by clinical and corporate performance indicators, whilst their effectiveness is measured by their ability to deliver sufficient, timely and appropriate health services to the population their hospital serves.

The emergent CD2E model that was discussed in this chapter describes the perceived dimensions of efficiency and effectiveness of a Clinical Director in the Western Australian context. It was found that domain knowledge and skills, business skills and personal attributes all contribute to the perceived efficiency and effectiveness of Clinical Directors. Each of these dimensions comprise of a number of components, for example, financial management, political expertise and communication skills to name a few. Some components of these dimensions are specific to doctors. In other words, they are skills, knowledge and abilities that doctors inherently bring to the role of a Clinical Director. However, some elements of these components require development in order for a Clinical Director to be considered successful in their role.

These issues will be discussed in the concluding chapter that follows.

Chapter 7 Conclusion

7.1 Introduction

The aim of this research was to determine the perceived dimensions of efficiency and effectiveness of Clinical Directors in Western Australia's major public teaching hospitals. This chapter presents the conclusions from the data analysis of this study in the form of a final model. It brings together the perceptions of the Chief Executives, Clinical Directors, Nurse Managers, Business Managers and Heads of Department who participated in this study, to form a model that can be used to describe the perceived dimensions of efficiency and effectiveness in a Western Australian context.

The final CD2E model not only describes the perceived dimensions of efficiency and effective, but it also outlines those dimensions that are brought to the role of a Clinical Director by the medical profession and those areas where there are deficiencies.

The chapter continues with discussion on the implications of the findings and the policy recommendations that are derived from them.

The chapter concludes with comments on the limitations of this study and areas for possible research in the future.

7.2 The Final CD2E Model

The final **C**linical **D**irector **E**fficiency and **E**ffectiveness (CD2E) model is illustrated on the following page. It draws together the dimensions of efficient and effective clinical directorship, those attributes that are brought to the role of a Clinical Director by the medical profession and those aspects of the role for which doctors require development. The final model will be discussed subsequently.
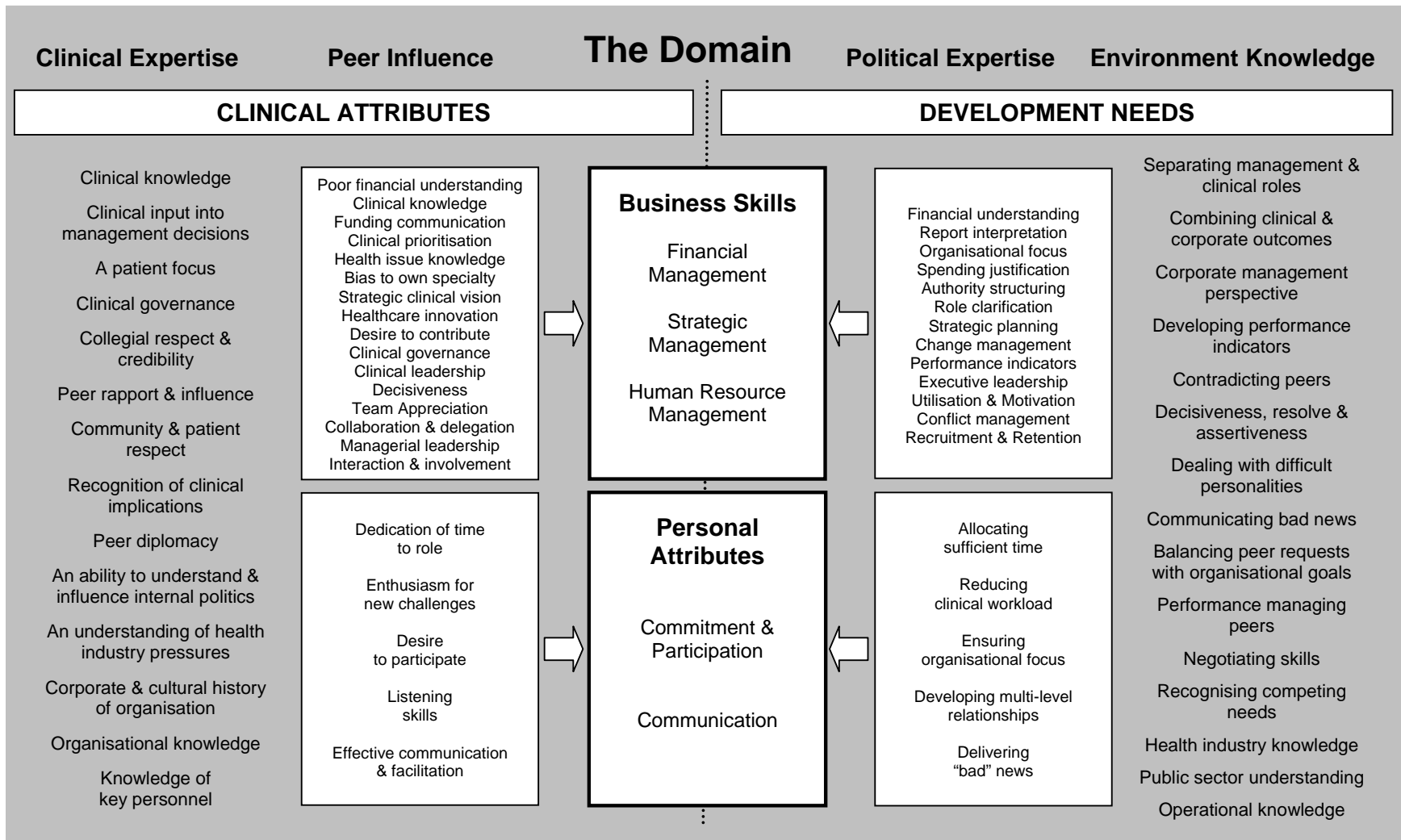
The Domain

Clinical Expertise   **Peer Influence**   **Political Expertise**   **Environment Knowledge**

CLINICAL ATTRIBUTES	DEVELOPMENT NEEDS

Clinical Attributes (left column):

Clinical knowledge

Clinical input into management decisions

A patient focus

Clinical governance

Collegial respect & credibility

Peer rapport & influence

Community & patient respect

Recognition of clinical implications

Peer diplomacy

An ability to understand & influence internal politics

An understanding of health industry pressures

Corporate & cultural history of organisation

Organisational knowledge

Knowledge of key personnel

Business Skills box (left inner):

Poor financial understanding
Clinical knowledge
Funding communication
Clinical prioritisation
Health issue knowledge
Bias to own specialty
Strategic clinical vision
Healthcare innovation
Desire to contribute
Clinical governance
Clinical leadership
Decisiveness
Team Appreciation
Collaboration & delegation
Managerial leadership
Interaction & involvement

Business Skills

Financial Management

Strategic Management

Human Resource Management

Business Skills box (right inner):

Financial understanding
Report interpretation
Organisational focus
Spending justification
Authority structuring
Role clarification
Strategic planning
Change management
Performance indicators
Executive leadership
Utilisation & Motivation
Conflict management
Recruitment & Retention

Personal Attributes box (left inner):

Dedication of time to role

Enthusiasm for new challenges

Desire to participate

Listening skills

Effective communication & facilitation

Personal Attributes

Commitment & Participation

Communication

Personal Attributes box (right inner):

Allocating sufficient time

Reducing clinical workload

Ensuring organisational focus

Developing multi-level relationships

Delivering "bad" news

Development Needs (right column):

Separating management & clinical roles

Combining clinical & corporate outcomes

Corporate management perspective

Developing performance indicators

Contradicting peers

Decisiveness, resolve & assertiveness

Dealing with difficult personalities

Communicating bad news

Balancing peer requests with organisational goals

Performance managing peers

Negotiating skills

Recognising competing needs

Health industry knowledge

Public sector understanding

Operational knowledge

Figure 7.1   The Final CD2E Model

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7.3 Discussion of the Final Model

The dimensions of efficient and effective clinical directorship in the Western Australian context are perceived to be 'Domain Knowledge and Skills', 'Business Skills' and 'Personal Attributes'.

7.3.1 Domain Knowledge and Skills in the Final Model

The health environment in which the Clinical Director manages guides the dimension of 'Domain Knowledge and Skills'. Although perceived in the context of the Western Australian health scene, the literature suggests that they would be common and applicable to other health environments.

The final model suggests that the dimension of 'Domain Knowledge and Skills' comprises four important components: clinical experience, peer influence, political expertise and environment knowledge.

Clinical experience could be considered the most important component of the final model, as it is this fundamental attribute upon which the clinical directorate model has been based. To be efficient and effective, a Clinical Director needs to be a current and practicing clinician. These crucial requirements are important in understanding current clinical issues and for building trust and credibility with clinical staff. By having an outlook that is patient focus and a good understanding of clinical issues, the successful Clinical Director can make management decisions that are backed by evidence-based medicine and sound clinical governance.

However, clinical experience alone is not sufficient for success. There are a number of areas that require further development for those doctors who take on management roles. The final model suggests that the efficient and effective Clinical Director must know how to separate their clinical and management roles. As such, they must be able to divorce themselves from their own self-, directorate-, specialty- or individual patient interests and make management decisions that have an organisational focus. Despite ethical dilemmas or patient obligations they may face, Clinical Directors must learn to satisfy both clinical and corporate outcomes through evidence-based medicine. By understanding both sides of the clinical and corporate argument, Clinical Directors are in a better position to make appropriate management decisions.

Another determinant of the success of the clinical directorate model is a Clinical Director's ability to influence their peers. Managing professionals, particularly those reputed to have large egos, difficult personalities and the tenet of clinical freedom on their side, can prove to be particularly difficult. The final model suggests that the level of credibility and respect that a Clinical Director can command from their peers is a determinant of the success they will have in dealing with them. It is proposed that it is only through credibility and respect that a Clinical Director can develop sufficient rapport with their peers to influence behaviour. Such respect can be gained through clinical accomplishments, community opinion or patient perception.

The final model also suggests that Clinical Directors possess a number of advantages over non-clinical managers in dealing with the medical profession. Unlike non-clinical managers, a Clinical Director can rally medical profession support for initiatives through their ability to see the clinical implications of management decisions. Similarly, their clinical knowledge can help them see through a non-sustainable clinical argument that could possibly bluff a non-clinical manager. In dealing with these types situations, it is important that the Clinical Director manages with an appropriate level of diplomacy. Saving face is an important concept to consider when dealing with medical professionals. The final model suggests that in contrast to non-clinical managers, Clinical Directors are better placed to deal in a diplomatic manner with confronting situations that involve doctors.

The final model proposes that Clinical Directors have a number of development needs in dealing with their peers. For example, regularly dealing with strong, complex and intelligent personalities can be quite confronting for a Clinical Director. Learning how to manage the medical profession 'personality' is an important requirement of successful clinical directorship. Clinical Directors must learn to be confident, decisive and assertive in dealing with their peers, particularly if contradiction is necessary. The final model considers performance management to an important tool in the management of peers. However, it is an exercise that is rarely done. Clinical Directors are not good at delivering bad news, whether it involves criticisms of a peer's performance or balancing a peer's request with organisational goals. The final model suggests that improvements in this aspect of a Clinical Director's performance will lead to greater success in their role.

Political expertise is also an important component of efficient and effective clinical directorship. By way of their standing within the organisation, their inherent clinical knowledge and professional respect, Clinical Directors are able to understand internal organisational politics, facilitate discussion and influence outcomes. Importantly, however, the advantages that Clinical Directors possess over their non-clinical counterparts need to be tempered with the recognition that clinical disciplines outside of the Clinical Director's directorate have equally important competing needs. The final model suggests that enhancing the communication and negotiation skills of Clinical Directors would serve to support their political endeavours.

An efficient and effective Clinical Director is one who also understands the environment in which they manage. That understanding is not only of the healthcare industry and the complex issues it faces, but also of their organisation, its history and its key players. It follows that an in-depth knowledge of the external and internal operating environment becomes an essential requirement for success. Despite this, the final model proposes that Clinical Directors often lack a mature knowledge of the general healthcare industry, its external politics and its funding models. Similarly, it is suggested that many Clinical Directors take on their role with little knowledge of how elements of their organisation operate, nor of public sector processes, policies and standards. The final model proposes that development in these areas is a requirement for successful clinical directorship.

7.3.2 Business Skills in the Final Model

Working in a management role dictates that Clinical Directors must be competent in a number of business skills in order to be efficient and effective. Whilst competency in these skills is a normal requirement of a professional manager, they are often unfamiliar and to some extent challenging to those in the medical profession. The suggested reasons are associated with the 'clinical mentality' of doctors and the medical profession's paucity of management education.

The final model suggests that the dimension of 'Business Skills' comprises three components: financial management, strategic management and human resource management.

As has been proposed by the final model, Clinical Directors generally have an inherent weakness in their understanding of business and financial issues. Having a basic understanding of finance and the ability to interpret and analyse financial reports were considered important competencies. Whilst Clinical Directors may have a deficit in these areas, it is important to appreciate that given time, such skills can be learned. In addition, the support mechanism provided by Business Managers can help Clinical Directors to transition from their clinical role to their management role.

Their clinical background, suggests the final model, enables Clinical Directors to determine clinical imperatives and what priorities require financing. Being an integral part of the finance process affords Clinical Directors an organisational perspective and the opportunity to communicate funding priorities to their peers. As has been previously highlighted, it is important in these situations for a Clinical Director to possess an organisational rather than directorate perspective. They must learn to justify expenditure and develop services through appropriate business planning.

The efficient and effective Clinical Director brings a number of important clinical attributes to the strategic management process. In having a broad knowledge of health issues, the final model suggests that Clinical Directors are able to apply a clinical direction to strategic vision. Furthermore, by maintaining a clinical component to their role, they are in a position to promote innovative methods for the delivery of health as well as develop, initiate and improve clinical indicators. The final model proposes that those who take on clinical directorships have a genuine interest in contributing to the strategic process. However, a meaningful contribution to strategic management can only occur if roles and responsibilities are clear and the management structure ensures a delegation of appropriate authority to Clinical Directors.

The final model also identifies a number of strategic management development needs. They include skills development in strategic management and business planning, change management and understanding corporate performance indicators. Whilst clinical directorate management teams are well placed to support Clinical Directors with these aspects of directorate management, the final model suggests that

the clinical directorate model can be more successful by Clinical Directors developing competencies in these areas.

Human resource management can prove demanding for even the most experienced professional manager. Like professional managers, Clinical Directors face the same challenges and issues. However, in dealing with clinical staff, their clinical leadership can offer some advantages over the professional manager. Being accustomed to a leadership role, they can collaborate well and delegate appropriately. The final model proposes that an important component of human resource management for a Clinical Director is staff interaction. Whether this is by way of appreciation of the skills and abilities of their directorate management team or by interest and involvement with staff at all levels, the success of the clinical directorate model is often gauged by staff's relationship with their Clinical Director.

Importantly, the final model offers some direction for the development needs of Clinical Directors in relation to human resource management. Again, it is essential that they have an organisational rather than representational focus. With this in mind, they must learn to lead from an executive rather than directorate perspective. The final model also highlights various human resource management skills that are required for successful clinical directorship. They are competencies in staff utilisation and motivation, team building, personal conflict management and recruitment and retention.

7.3.3 Personal Attributes in the Final Model

By virtue of their clinical background, Clinical Directors bring to their role a number of intra- and inter-personal attributes.

The final model proposes that Clinical Directors need to bring to the role a desire to be involved in corporate decision-making and the management process and an enthusiasm to take on new challenges. This willingness to participate requires a substantial commitment on behalf of a Clinical Director. Importantly, the reason for participation must be to some extent altruistic. The efficient and effective Clinical Director is one who looks to benefit the organisation rather than themselves.

Whilst the final model shows that Clinical Directors demonstrate a willingness to dedicate time to the management role, the time actually allocated to the role is often insufficient. The conflicting demands between clinical and management time poses many problems for time-deprived Clinical Directors. The final model proposes that a reduction in clinical workload would benefit Clinical Directors and the directorate model. It appears that 2 sessions (7 hours) per week is simply not enough time to fulfil all the requirements of the role. Increasing the amount of management sessions would, however, face resistance from clinicians who wish to maintain their clinical involvement and management who would be forced to deal with the cost implications.

Good communication skills are a valued attribute that doctors bring to the role of clinical directorship. The abilities to listen well, communicate information effectively and facilitate discussion are attributes that are borne of the clinical background. Despite their excellent communication skills, Clinical Directors (like all professional managers) must learn the difficult task of delivering 'bad' news. In a difficult health environment, tough decisions need to be supported by the courage of conviction.

Importantly, the final model proposes that Clinical Directors should place a greater emphasis on developing relationships at all levels of the organisation. Whilst Clinical Directors find it natural to communicate with their medical colleagues, they often have little to do with staff below the middle management level. It is suggested that one of the strengths of the clinical directorate model is that it is well placed to bring the Executive to the staff. Bearing this in mind, the model suggests that the successful Clinical Director is one who promotes their accessibility to all staff.

7.4   Implications of Findings

The findings have illustrated that a Clinical Director's efficiency and effectiveness are important to the success of the clinical directorate model. Whilst the medical profession makes a valuable contribution by way of the specific attributes they bring to the role of a Clinical Director, the data suggest that those who take on the role have a number of development needs. From the study, it is perceived that in the Western Australian context, Clinical Directors require some form of development, education

and training in a number of areas. The following table details the desirable knowledge, competencies and behaviours of efficient and effective Clinical Directors.

Environment and Knowledge Development

- To separate management and clinical roles
- To combine clinical and corporate outcomes
- To develop a corporate management perspective
- To participate in the development of meaningful performance indicators
- To be able to contradict peers when necessary
- To be decisive, resolute and assertive in their management dealings
- To deal with strong, complex and difficult personalities
- To communicate 'bad' news when necessary
- To balance the requests of medical colleagues with organisational goals
- To negotiate successful outcomes
- To recognise competing needs across the entire organisation
- To be aware of issues across all of the health industry
- To be conscious of public sector processes, policies and standards
- To appreciate all operational aspects of the organisation

Business Skill Development

- To have an understanding of financial issues
- To interpret and analyse financial reports
- To develop an organisational focus
- To be able to justify spending through appropriate business planning
- To develop an organisational structure in which authority is fully devolved
- To clarify directorate/director roles and responsibilities
- To be able to plan strategically
- To manage change appropriately
- To participate in the development of meaningful performance indicators
- To provide Executive leadership
- To utilise and motivate staff appropriately
- To manage interpersonal conflict
- To recruit and retain staff successfully

Personal Attribute Development and Requirements

- To allocate sufficient time to management role
- To reduce clinical workload given greater management responsibilities
- To focus on working for the greater good of the organisation
- To have multi-level relationships across the organisation
- To be able to deliver 'bad' news

Table 7.1   Desirable Knowledge, Competencies and Behaviours

Determining how to address the development needs requires careful consideration. As has been demonstrated by this study, devolving management to doctors brings together many complex and interacting issues.

The literature comments that even though there has been a concerted push for doctors to be involved in management over the past two decades, low priority has been given to doctors' education in this area (Kirkpatrick et al, 2007; Mark, 1994). The findings for this study showed that of the 13 Clinical Directors interviewed, 12 (92%) had participated in some form of in-service management or leadership training, but only 2 (15%) had tertiary qualifications in the area.

Importantly, the management development of potential and current Clinical Directors needs to be a proactive rather than reactive exercise (LeTourneau and Curry, 1998). It cannot be assumed that the management skills required by Clinical Directors are simply an extension of their clinical skills (Shortland and Gatrell, 2005). Relevant programmes that take into account the paucity of busy clinicians' time need to be developed. It is suggested that the development needs revealed by this study are of relevance for those doctors who take on clinical directorships in Western Australia's public teaching hospitals.

7.5 Policy Recommendations

It is proposed that the development needs of current and future Clinical Directors can be met through a combination of relevant undergraduate education, in-service training and development, mentoring and inducement.

7.5.1 Undergraduate Education

Both Mark (1994) and Kusy et al (1995) believe that management training and development should start early in a doctor's medical career and be a consistent part of their development. Unfortunately, the Western Australian experience has not progressed so far as to appreciate this concept. As illustrated by the University of Western Australia curriculum in appendix 7, medical training in Western Australia includes no management, business or leadership components.

Recommendation 1: Business, management and leadership course units to be incorporated into undergraduate medical training.

7.5.2   Training & Development

Many of the business concepts mentioned throughout this thesis can be learned through university courses in Public Health, Business or Health Service Management. However, such courses are probably more suited for career medical administrators rather than Clinical Directors (Kearney, 1991).

Rather than relying on busy doctors with clinical obligations committing to formal tertiary education courses, Western Australian hospitals would be well served to develop relevant in-service educational programmes explicitly for Clinical Directors. The programmes could be tailored to meet the educational needs of Clinical Directors from a specific organisational perspective. The syllabi could be constructed to take into account the three dimensions of efficiency and effectiveness identified by this research. Specific topics could be guided by the development needs that have been revealed.

Kitchener (2000) reports that Chief Executives generally welcome this sort of programme and are encouraged by the opportunity for Clinical Directors to be exposed to commercial practices and ideas. Fitzgerald (1994) reports that in-house programmes also generate a great deal of confidence for Clinical Directors. They find them particularly rewarding when given the opportunity to mix with other managers. In some cases, reports Kitchener (2000), in-house programmes have led to Clinical Directors progressing to formal tertiary education by way of MBAs.

> **Recommendation 2:   In-house management programmes, specifically tailored to meet the development needs of Clinical Directors, be established at all three public teaching hospitals.**

7.5.3   Mentoring

Mentoring offers a process by which the development of Clinical Directors can be made easier (Stroobant, 1995). Unfortunately, it is a concept that is not widely promoted in the Western Australian context.

Research by Kusy et al (1994) found that doctors in management positions believed having a mentor helped them to more quickly develop the skills they viewed as critical to their effectiveness. A mentor not only accelerated their learning, but also created a personal support system that assisted in career path development. Lyons et al (1996) similarly found that mentors play an important role in the success of doctors in management. According to Lyons et al (1996:25) the specific benefits that mentors provide are:

- An awareness of educational opportunities and career growth.
- An example/model of executive behaviour and leadership.
- Direction and guidance at decision points.
- Development through personal and professional advice.
- Coaching, encouragement, support and feedback.

If adopted, these benefits would no doubt generate greater efficiency and effectiveness of future Clinical Directors in the Western Australian system.

> **Recommendation 3:   Mentoring in management programmes be developed and incorporated into the training programmes of junior doctors at public teaching hospitals.**

7.5.4   Inducement

Providing incentive for those doctors who take on management responsibilities is important for the encouragement and maintenance of their involvement.   The National Health Service in the United Kingdom, for example, awards 'merit pay' to:

> "…those physicians who display commitment to the management of
> their specialties as well as clinical excellence."

> (Kitchener, 2000:140)

In Western Australia, a similar scheme operates. Clinical Directors are paid an allowance above their pay level in recognition of their managerial responsibilities. The incremental increase in pay, however, is small relative to the rewards of private

sector medicine. It is proposed that a review be conducted to determine what level of financial remuneration will attract and retain the highest calibre of doctors to management roles.

> **Recommendation 4: A review be conducted to determine the level of remuneration that is required to entice high calibre doctors to management roles.**

7.6   Limitations of the Findings

There are various limitations that are inherent to this study due to its qualitative nature (Chadwick et al, 1984). The researcher has sought to overcome them through attention to the issues of rigour.

The setting and construct for this study present a number of specific limitations. It is believed that the contextual and design limitations are that:

- It is a study within the unique setting of the Western Australian health system's public teaching hospitals.
- Emphasis for this study was placed upon the perceptions of select groups of respondents. It has to be acknowledged that others within the hospital context with whom the Clinical Director interacts may not share the perceptions of the members of the groups interviewed.
- As the phenomena studied are intimately tied to the time and context in which they are found, generalisation of the findings is precluded.

Despite these limitations, it is proposed that the careful documentation of the methodology together with an acknowledgement of underlying assumptions (see Chapter 3), will allow this study to be compared with other findings from different settings.

7.7 Future Research

In studying the dimensions of efficiency and effectiveness of Clinical Directors in the Western Australian context, various areas for potential research and themes for hospital review have been identified.

7.7.1 Areas for Potential Research

This study has looked at the perceived dimensions of efficiency and effectiveness from the perspective of Chief Executives, Clinical Directors, directorate management teams and Department Heads. Determining the dimensions from the perspective of other subordinates and/or medical colleagues would provide an interesting focus for future research.

Similarly, future research could compare and contrast the perceptions of all the groups mentioned above, in order to determine if there are any common or diverging themes.

Given that this study has a purely Western Australian perspective, a comparison of the findings with another geographical context would provide an interesting insight into the similarities and/or differences in perceived dimensions.

This study has also identified the differences in directorate models that exist between hospitals. Determining whether or not different structures possess unique dimensions of efficiency and effectiveness would provide a greater insight into the development requirements of specific directorate models.

7.7.2 Themes for Hospital Review

It is suggested that hospitals within the Western Australian public sector could conduct in-house or co-operative reviews in order to answer a number of the issues that have been raised by this study. Suggestions include:

- Determining what amount of time should be allocated to a Clinical Director in order for them to successfully fulfil their management responsibilities.

- Determining the most appropriate level of remuneration to attract and retain high calibre Clinical Directors to the public health sector.

- Creating a managerial leadership programme for doctors that originates prior to Registrar training.

- Developing standards for effective mentoring.

- Creating an inventory of training opportunities available for Clinical Directors.

- Studying and/or designing the most effective learning methods for Clinical Director education and training.

7.8   Concluding Comment

Like health systems worldwide, the Western Australian health system has been under enormous funding and service provision pressure for the past two decades.   The introduction of devolved management models that incorporate clinical directorate structures has been seen as an answer to the demands placed on Western Australia's health system.

The directorate structures at Royal Perth, Sir Charles Gairdner and Fremantle Hospitals have now been in place for nearly 15 years.   Although subtle structural variations have occurred over time, it appears that devolved management structures will continue as the preferred model for hospital management into the future.

It is therefore important that the doctors who are charged with the responsibility of managing clinical directorates are both efficient and effective in their roles.   It is believed that this research has contributed to this requirement by providing a model that can be used to address the development requirements of current and future Clinical Directors.

Appendix 1: Researcher's Statement of Involvement

The researcher possesses a clinical background in Diagnostic Radiography, having graduated with a Diploma of Applied Science in 1983. For a 3-year period after graduation, the researcher was employed by the Health Department of Western Australia as a Relieving Radiographer. During this period, the researcher worked at more than a dozen country health service and secondary metropolitan hospitals.

In late 1985, the researcher commenced employment at Fremantle Hospital as a base-grade Radiographer and over a 10-year period progressed through a number of senior positions.

After having graduated with a MBA in 1995, the researcher obtained the position of Manager-Cardiac Services at Fremantle Hospital. It was at this time that the prospect of restructuring the hospital along the lines of clinical directorates commenced. Along with a number of clinical and senior management staff, the researcher participated in a weekend strategic seminar at York (Western Australia) to discuss the possible structure and implementation of devolved management for Fremantle Hospital.

Having a dual clinical and management background, the researcher was able to view the impact of devolved management from both perspectives. The position of Manager-Cardiac Services was a middle management position located within the Surgical Directorate at Fremantle Hospital. The researcher, however, experienced involvement in a directorate management team, by acting in the position of Business Manager-Surgical Services for a period of 3 months in 2000.

In 2001, the researcher moved to part-time in the public sector (still retaining the position of Manager-Cardiac Services) to commence employment as General Manager of a private sector cardiology practice.

In 2006, whilst still working part-time in the public sector, the researcher again participated in a directorate management team by acting in the inaugural position of Business Manager-Critical Care for a 3-month period.

Today, the researcher is still employed in both the private and public sectors. The private sector General Manager role has continued, whilst in the public sector, the researcher has taken on clinical responsibilities through employment as a Senior Medical Imaging Technologist in the Cardiac Catheter Theatre at Fremantle Hospital.

Appendix 2: Final Interview Schedule

Could we start by you telling me a little about yourself?

1. Tell me, what's your background?
2. How long have you been working here?
3. Could you describe what your job entails?

The main purpose of my research is to look at what is perceived to make a physician an efficient and effective Clinical Director. To start, I would like to focus on your organisational structure and the role of the doctors who head the directorates within it.

4. Tell me, how long have you had a directorate structure here?
5. Could you explain to me how the organisational structure's set up and how it works?
6. So, where do you fit within the directorate system?
7. Were you here before directorates were implemented?

If yes, then proceed with following questions. If no, go to question 12.

8. Briefly, tell me what was it like then (before directorates were established) – how did the system work?
9. Can you tell me your perception of how things have changed with the introduction of Clinical Directorates?
10. What's your perception of the benefits of the change?
11. What's your perception of the draw-backs (problems, costs etc) of the change?

Let's now move on to discuss the role of the physicians that head the directorates.

12. Speaking about their general role, what attributes do you think make a physician a good Clinical Director?
13. What special attributes do you feel a physician brings to the role of a Clinical Director?
14. What physician attributes may hinder a Physician Clinical Director in their role?

What I'd like to do now is to discuss the efficiency and effectiveness of their role.

If efficiency is defined as utilising resources appropriately, I'd like you to tell me:

15. What would be the criteria you would use for measuring the efficiency of a Physician Clinical Director role?
16. Against your criteria, how efficiently do you think Physician Clinical Directors perform their role within the hospital? Why's that?

If effectiveness is defined as the successful achievement of organisational goals:

17. What would be the criteria you would use for measuring the effectiveness of a Physician Clinical Director role?
18. Against your criteria, how effectively do you think Physician Clinical Directors perform their role within the hospital? Why's that?
19. Do you think you look at the efficiency and effectiveness of Clinical Directors in a different light to others in the hospital? For example, do you think you gauge how successful they are differently to say, their colleagues or the Chief Executive? (Substitute positions as necessary)
20. Can you think of any obstacles that make the performance of their role difficult?
21. In what ways do you think the next generation of Clinical Directors will be similar or different to as those we have today?
22. Is there anything that you would like to add before we finish the interview?

Appendix 3: Letter Seeking Permission

CURTIN BUSINESS SCHOOL

Graduate School of Business

Chief Executive
Royal Perth Hospital
Wellington Street
PERTH WA 6000

Level 30, QV1 Building
250 St Georges Terrace
Perth WA 6000

TELEPHONE +61 8 9266 3460
FACSIMILE +61 8 9266 3368
WEB PAGE http://www.gsb.curtin.edu.au

1st December, 2002

Dear Sir,

Re: Permission to Conduct Research Interviews at Royal Perth Hospital

I am a Doctoral Candidate from the Curtin University Graduate School of Business and am
seeking your permission to conduct a series of interviews at Royal Perth Hospital as part of
my research programme.

The purpose of my research is to examine the dimensions of efficiency and effectiveness of
the Physician Clinical Director's role in Western Australia's major public teaching hospitals.
I hope to conduct a series of semi-structured interviews with a cross-section of staff that
include Chief Executives, Clinical Directors, Business Managers, Nurse Managers,
Physicians, Senior Allied Health Professionals and Senior Nurses. A copy of the abstract
of my research proposal is attached for your information.

I anticipate the interview process will only take approximately one hour. All participation will
be voluntary and I intend for the interviews to be conducted only at a time that is convenient
to your staff.

Please be assured that my study has undergone the rigours of Candidacy and the approval
of the Curtin University Human Research Ethics Committee. If verification is required, it
can be obtained by either writing to the Committee at the above address or by telephoning
9266 2784.

Upon completion of the study, I would like to offer the results of my research to your
hospital in recognition of its contribution.

Thank you for considering my request.

Yours faithfully,

Graeme Dedman Dip App Sc, MBA
Doctoral Candidate
Curtin University - Graduate School of Business

Appendix 4: Letter of Permission

Department of Health
Government of Western Australia
East Metropolitan Health Service

Royal Perth Hospital
ABN 13 993 250 709

Dear Colleague

PERMISSION TO CONDUCT RESEARCH INTERVIEWS AT ROYAL PERTH HOSPITAL

I have given permission to Mr Graeme Dedman, a Doctoral Candidate from Curtin University Graduate School of Business, to conduct a series of interviews at Royal Perth Hospital as part of his research program.

The purpose of his research is to examine the dimensions of efficiency and effectiveness of the Physician Clinical Director's role in Western Australia's major public teaching hospitals. He would like to conduct a series of semi structured interviews with a variety of staff including the Chief Executive, Clinical Directors, Business Managers, Nursing Directors, Physicians, Senior Allied Health Professionals and Senior Nurses.

The interviews are expected to take approximately one hour with all participation voluntary and interviews conducted at times convenient to staff. I have been assured that this study has undergone the rigours of candidacy and has been approved by the Curtin University Human Research Ethics Committee.

At the completion of his study, Mr Dedman has offered to supply the results of his research to Royal Perth Hospital in recognition of its contribution. Please make him feel welcome and provide your assistance where possible.

Yours sincerely

Area Chief Executive

06 January 2003

Appendix 5: Biographical Questionnaire

CURTIN BUSINESS SCHOOL

Graduate School of Business

Curtin
UNIVERSITY OF TECHNOLOGY

Level 30, QV1 Building
250 St Georges Terrace
Perth WA 6000

TELEPHONE +61 8 9266 3460
FACSIMILE +61 8 9266 3368
WEB PAGE http://www.gsb.curtin.edu.au

Biographical Questionnaire

Code: _____
(Office use only)

Institution: FH&HS   RPH   SCGH

Directorate/Division: _____

Department: _____

Position: _____

Age: 21-30   31-40   41-50   51-60   60+

Employment Condition: **Full Time**   **Part Time**   **Sessional**

How many years have you been in the position you currently hold?

      <1   1   2   3   4   5   6   7   >7

Are you the inaugural holder of this position?   Yes   No
 (For Directorate/Divisional Management Team only)

How many others have held the position you are now in?
(For Directorate/Divisional Management Team only)

            1   2   3   4   5   >5

What are your tertiary qualifications?

_____

_____

_____

**Have you any formal management/leadership education or received any
in-service management/leadership training?**

            Yes   No

Appendix 6: Job Description Form (Clinical Director)

DEPARTMENT OF HEALTH
South Metropolitan Area Health Service

FREMANTLE HOSPITAL & HEALTH SERVICE

CLINICAL DIRECTOR – MEDICAL SERVICES

Job Description:

Leadership responsibility for the development, management and maintenance of high quality clinical services consistent with the South Metropolitan Coastal Group clinical and corporate priorities.

Responsible for the development and promotion of strategies to bring about clinical reform.

Contributes as a member of the Coastal Group Executive team to corporate level strategic planning and decision-making.

Responsible for the Medical Directorate activity and budget performance in close liaison with other Directorate management team members.

Heads the development and implementation of programs to monitor the safety, efficiency and effectiveness of clinical services in the Medical Directorate.

Participates in a continuous process to monitor, evaluate and enhance the performance of departments within the Directorate.

Responsible for the management of Medical Directorate staff in close liaison with management team members and in accordance with Human Resource policies and practices and Coastal Group policies.

Promotes and fosters the Medical Directorate quality improvement programs with an emphasis on patient focussed quality improvement initiatives. Ensures the Medical Directorate meets the requirement for ACHS accreditation.

Responsible for the management of risk within the Directorate and integrating this with the Coastal Groups' risk management process.

Responsible for the allocation of the Directorate's resources in line with outcome related activity.

Promotes and fosters the Medical Directorate's teaching, research and professional development programs.

Performs duties in accordance with relevant Occupational Health and Safety and Equal Opportunity Legislation.

Performs duties in accordance with the South Metropolitan Area Health Service and program specific Policies and Procedures.

Other duties as directed.

Selection Criteria:

Essential:

1. Medical degree registered in WA and relevant specialist qualifications.
2. Effective communication and interpersonal skills.
3. Knowledge of strategic planning and policy formulation.
4. Highly developed conceptual and analytical skills.
5. Demonstrated organisational and change management skills.
6. Current knowledge of legislative obligations for Equal Opportunity, Disability Services and Occupational Safety and Health, and how these impact on employment and service delivery.

Desirable:

1. An understanding of current Human Resource issues, including industrial relations issues.
2. Knowledge of current issues facing the WA health industry.
3. Management experience at department level in a teaching hospital including performance management.
4. Understanding of Quality Improvement and risk management programs.

Source: Fremantle Hospital (2008)

Appendix 7: University of WA Curriculum (MBBS)

First Year MBBS units

IMED1100   Normal Systems
IMED1106   Foundations of Animal and Human Biology
IMED1107   Foundations of Medical Chemistry
IMED1111   Foundations of Clinical Practice
IMED1112   Foundations of Clinical Practice
IMED1113   Molecules, Genes and Cells 1
IMED1113   Molecules, Genes and Cells 2

Second Year MBBS units

Core units	**Optional units**	
IMED2201 Normal Systems	IMED2205 Health Research Design	
IMED2202 Normal Systems	IMED2206 Physiology of Adaptation and Stress	
IMED2211 Foundations of Clinical Practice	IMED2207 Plagues, Pox and Pandemics	
IMED2212 Foundations of Clinical Practice	IMED2264 Physiological Control Mechanisms	
IMED2231 Normal Systems 1	IMED2282 Biological Anthropology	
IMED2232 Normal Systems 2	IMED2283 Surgical and Clinical Anatomy	
	IMED2292 Public Health and Health Care Systems	
	IMED2293 Aboriginal Health	
	IMED2301 Experimental Molecular & Genetic Medicine 1	
	IMED2302 Experimental Molecular & Genetic Medicine 2	
	PUBH2208 Food and Nutrition in Public Health	
	SCIE2203 Bioinformatics	

Third Year MBBS units

Core units	**Optional units**	
IMED3311 Foundations of Clinical Practice	IMED3304 Health Research Design	
IMED3312 Foundations of Clinical Practice	IMED3305 Diagnostic Medical Microbiology	
IMED3340 Infectious Diseases 1	IMED3307 Clinical Immunology and Immunopathology	
IMED3341 Infectious Diseases 2	IMED3308 Legal Medicine	
IMED3342 Foundations & Systemic Pathology 1	IMED3309 Medical Genetics	
IMED3343 Foundations & Systemic Pathology 2	IMED3310 Pathology (Human Oncobiology)	
IMED3344 Medical Pharmacology 1	IMED3313 People, Health and Sexuality	
IMED3345 Medical Pharmacology 2	IMED3315 Adolescent Sexuality & Community Health	
	IMED 3318 Psychology of Healing	
	IMED3320 Forensic and Necropsy Pathology	
	IMED3329 Plagues, Pox and Pandemics	
	IMED3393 Aboriginal Health	
	IMED3401 Rural Health Care Part 1	
	IMED3402 Rural Health Care Part 2	
	IMED3411 Community-based Care for Chronic Conditions 1	
	IMED3412 Community-based Care for Chronic Conditions 2	
	IMED3421 Aboriginal Community Organisation Placement 1	
	IMED3422 Aboriginal Community Organisation Placement 2	

Fourth Year MBBS units

IMED4401   Science and Practice of Medicine 1
IMED4402   Science and Practice of Medicine 2
IMED4403   Preparation for Practice
IMED4411   Clinical Skills 1
IMED4412   Clinical Skills 2
IMED4421   Personal & Professional Dev 1
IMED4422   Personal & Professional Dev 2
IMED4431   Infectious Diseases 1
IMED4432   Clinical Pathology and Lab Med 1
IMED4442   Clinical Pathology and Lab Med 2
IMED4451   Clinical Pharm and Therapeutics 1
IMED4452   Clinical Pharm and Therapeutics2
IMED4461   Medicine 1
IMED4462   Medicine 2
IMED 4471   Psychiatry 1
IMED 4472   Psychiatry 2
IMED4481   Surgery 1

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IMED4482      Surgery 2
IMED4491      Medicine Specialties 1
IMED4492      Medicine Specialties 2
IMED4501      Research and Discovery 1
IMED4502      Research and Discovery 2
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Fifth Year MBBS units

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IMED5501      Science and Practice of Medicine 1
IMED5502      Science and Practice of Medicine 2
IMED5511      Special Clinical Skills 1
IMED5512      Special Clinical Skills Part 2
IMED5521      Personal and Professional Dev Part 1
IMED5522      Personal and Professional Dev Part 2
IMED5531      General Practice Part 1
IMED5532      General Practice Part 2
IMED5541      Obstetrics and Gynaecology Part 1
IMED5542      Obstetrics and Gynaecology Part 2
IMED5551      Paediatrics Part 1
IMED5552      Paediatrics Part 2
IMED5561      Medicine Part 1
IMED5562      Medicine 2
IMED5591      Medicine Specialties Part 1
IMED5592      Medicine Specialties Part 2
IMED5601      Options Part 1
IMED5602      Options 2
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Sixth Year MBBS units

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IMED6601      Science and Practice of Medicine Part 1
IMED6602      Science and Practice of Medicine Part 2
IMED6621      Personal and Professional Development Part 1
IMED6622      Personal and Professional Development Part 2
IMED6631      Rural General Practice Part 1
IMED6632      Rural General Practice Part 2
IMED6651      Emergency Medicine Part 1
IMED6652      Emergency Medicine Part 2
IMED6661      Medicine Part 1
IMED6662      Medicine Part 2
IMED6671      Psychiatry 660 Part 1
IMED6672      Psychiatry 660 Part 2
IMED6681      Surgery 670 Part 1
IMED6682      Surgery 670 Part 2
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Source: University of Western Australia (2008)

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