

**The Dimensions of Efficiency and Effectiveness of Clinical Directors:  
Perceptions of Clinical Directors and Senior Management  
in Western Australian Public Teaching Hospitals**

**Efficiency and Effectiveness of Clinical Directors**

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## **Abstract**

Health systems have elected to devolve management to semi-autonomous clinical sub-units, known as 'Clinical Directorates'. This has placed responsibility for managing diminishing healthcare resources primarily in the hands of those who use them, notably medical practitioners. This research examines and presents a framework that describes the dimensions of efficient and effective Clinical Directorship in the context of a devolved management structure. A qualitative research design was employed to explore the perceptions of those involved in the operation of Clinical Directorates some ten years after their implementation at three public teaching hospitals in Western Australia.

The research found that the clinical insights which medical practitioners bring to the role of Clinical Director were perceived to be the grounding for clinical directorate effectiveness. Clinical knowledge combined with contextual knowledge, understanding of the politics of healthcare and ability to influence medical peers, were seen as critical. However, having business skills, commitment and good communication skills were perceived to be important to achieve both effectiveness and efficiency. The paper describes the dimensions of Clinical Director competence and the competencies, skills and knowledge perceived as requiring further development. It highlights the problems and issues that can arise for Clinical Directors from the perspectives of Directors and their management teams.

**Keywords:** Clinical Directorate, Clinical Director, public hospital reform, healthcare management reform, devolved hospital management.

## **Introduction**

Pressure to not only reduce costs in relative terms but also to provide new and expanded services, has caused hospitals worldwide to closely examine the means by which they meet the demands placed upon them.<sup>1</sup> The devolution of management and the creation of semi-autonomous clinical sub-units, or clinical directorates, was one of the responses of public hospitals. First introduced by Baltimore's Johns Hopkins Hospital in 1974,<sup>2</sup> the clinical directorate model resulted in significant organisational restructuring of hospitals. Medical specialties or groups of specialties were combined into single semi-autonomous entities, each having full budgetary and clinical decision-making authority. This strategy was designed to place responsibility for managing diminishing healthcare resources into the hands of those who use them, notably medical practitioners. Expected benefits included greater clinical input into the development and prioritisation of health service strategies, improved patient care coordination, enhanced communication between clinical and management groups and more effective and efficient spending of the health dollar.<sup>3</sup>

Over a four year period, 1994 to 1997 clinical directorates were sequentially established in all of the major public teaching hospitals in Perth, Western Australia. This paper reports on qualitative research undertaken between eight and ten years after clinical directorate structures were implemented in these hospitals. The paper explores the perceptions of those involved in the operation of well-established clinical directorates and provides an emergent model for Clinical Director efficiency and effectiveness. It highlights the problems and issues that can arise for Clinical Directors from the perspective of the Directors and their management teams.

## **Conceptual framework**

The public sector paradigm has moved from an administrative focus to one that is based on outcomes.<sup>4</sup> The model is designed to give managers the freedom to manage, generate results and improve organisational performance, whilst at the same time, de-politicising policy making by reducing the State's role in service delivery.<sup>4,5</sup> As a consequence, private sector management practices such as budgets and mission statements have been promoted and incorporated into the public sector.

New Public Management (NPM) reforms, however, can be counter-productive, promoting conflict, distrust and dissatisfaction within the workplace, notably among professional workers.<sup>5,6</sup> The inherent tension between the professional values of health professionals and demands for improved efficiency, cost control and resource allocation have highlighted the reluctance of medical professionals to adopt management values and priorities,<sup>7</sup> curtailed clinical autonomy and created "suspicion of management".<sup>8,9</sup> Rather than autocratic management, these professional groups require managers who are "able to lead from the side" through support, co-ordination and facilitation.<sup>10</sup> Simpson argues 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.<sup>10</sup>

The participation of doctors in management is also supported from an operational perspective. The great majority of costs generated within a hospital are a consequence of the clinical practices of doctors. It therefore follows that decision-making in respect to the allocation of finite resources should involve clinical staff.<sup>11,12</sup>

The two most commonly described types of organisational design in hospitals are the functional and directorate structures. The functional organisational structure is considered a traditional professional structure, where departments are grouped according to the type of work they do.<sup>13</sup>

With this form, the chain of command is vertical and decision-making is centralised. It relies on routine, explicit rules and well-documented procedures to create efficiency.

The limitation of this structure is its natural tendency to lead to the fragmentation of patient care.<sup>14</sup> Managers are accountable for the performance of their departments rather than the performance and growth of service lines. Other disadvantages include inadequate communication, a lack of focus, inefficient bureaucracy and difficulties in implementing strategies that bridge multiple departments.<sup>15,13</sup>

The second form of organisational design common to hospitals is that of the clinical directorate, defined 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.”<sup>16</sup>*

The clinical directorate model can be either divisional or service line in structure.<sup>17,18</sup> A clinical division groups services along traditional medical lines such as Divisions of Medicine and Surgery. In the late 1980s and early 1990s many hospitals began to align clinical units according to “service” lines such as cancer services and cardiac services. The introduction of funding for diagnosis related groupings (DRG) further convinced hospitals to think in terms of these types of groupings.

Directorates in service-line structures are believed to promote co-ordinated patient care, quickly identify changes in the operating environment, provide clinical input into strategic development, improve resource utilisation, enhance communication and facilitate cross-discipline involvement.

<sup>12,14</sup> The most common elements of a directorate management team are a Clinical Director, a Nurse Manager and a Business Manager.<sup>19</sup> In some organisations, a General Medical Practitioner may also be included to provide contact with the local community.

The Clinical Director is a consultant member of one of the specialties within the directorate.

They report to the Chief Executive and commonly hold a position on the hospital's executive.<sup>20</sup>

The Clinical Director takes total responsibility for their directorate's service quality, volume and cost. Termed "management from the inside", <sup>2</sup> the model puts medical managers into positions of authority over decisions made by colleagues.

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.<sup>21</sup> The perpetuation of parallel hierarchies and the constraint of traditional business practices have impeded the change process in hospitals.<sup>22</sup> Perceived distrust between managers and doctors is also noted.<sup>10,2</sup>

This is often exacerbated by the different worldviews, thought styles, orientations, expectations and cultures that each group possess.

The proposed benefits of clinical directorates are based on the assumption that when management is devolved to a doctor, they will be able to provide a level of management that is equivalent to that of a professional manager. However, it has been argued that the concepts of management are foreign to doctors who operate from a completely different paradigm.<sup>11,24</sup>

## **Research Method**

The research was undertaken in an Australian context. The Australian healthcare system is a universal system that involves a mix of public and private sectors. Both Federal and State governments are involved in the provision of healthcare. Funding is sourced from Federal, State and Local government, individuals, non-government organisations and health insurance.

The study's primary focus was upon doctors employed as Clinical Directors in Western Australian public teaching hospitals. It sought to discover and provide an understanding of how these Clinical Directors perform their job well. It did this by examining their perceptions as well as those of their Chief Executives, medical colleagues and management teams.

In Western Australia, the implementation of clinical directorates has been used as a response to the increasing demands for cost constraint and improved efficiency. The clinical directorate structure in Western Australian public teaching hospitals is one in which a Clinical Director has either ultimate or joint authority, responsibility and accountability for a directorate. Each of the three hospitals that participated in this study introduced clinical directorate structures in the mid 1990s. While in two of the hospitals a doctor took ultimate responsibility for management, one introduced a co-director model, whereby a doctor and a nurse were jointly responsible for the directorate's management. Although the structure and nomenclature adopted by each hospital varies, the concept of devolving management to doctors is common to all.

The main objective of the study was to examine and present a framework that describes the dimensions of an efficient and effective Clinical Director in a devolved management structure.

A key assumption that subtended the study was that the dimensions of efficiency and effectiveness of Clinical Directors were not influenced by the differing organisational structures that existed across the hospitals studied.

A qualitative research design was chosen as such an approach is most suited to topics that need exploration, have variables that are not easily identified, theories that are yet to be developed and processes that go beyond surface appearance.<sup>25,26</sup> To demonstrate rigour, the researchers employed decision trails as well as the triangulation of data across different sites and information sources.<sup>27</sup>

Data were collected over a 19-month period between April 2002 and November 2003 via semi-structured interviews, biographical data sheets and sourcing of relevant documents. Interviews with 3 Chief Executives, 13 Clinical Directors, 12 Nursing Directors, 9 Business Managers and 2 Department Heads at three Western Australian public teaching hospitals were recorded. Data management was assisted by the use of qualitative research software -QSR•NUDIST. Following preparation of the data for analysis, the data underwent a structured coding process involving open coding (initial and focused), theoretical coding and memo writing. Content analysis of the interviews was performed using grounded research techniques.<sup>28</sup>

## **Findings**

The findings of this research are described under the three major categories which emerged.

They are: Domain Knowledge and Skills, Business Skills and Personal Attributes.

### **Domain Knowledge and Skills**

The clinical skills and knowledge, access to peers and related knowledge of the health system that medical practitioners were expected to bring to the role of Clinical Director have been projected as attributes which make doctors appropriate as decision makers in the allocation and management of finite health resources<sup>33,12</sup> Our respondents identified the following:

#### ***Knowledge of the Health Environment***

Knowledge of the public health environment was seen as an essential element for effective and efficient decisions to be made by Clinical Directors. As one Clinical Director pointed out:

*“One of the real issues for me - and what I think is important for Clinical Directors, is that [we] need to ... understand the ... broad operations of the public health system and how [they] influence the way we ... undertake the administrative role.”*

#### ***Political Expertise***



The effective Clinical Director needs to identify and understand individual interests, build on informal alliances and utilize symbols to shape organizational life.<sup>29</sup> They must be able to look past inter- and intra-directorate rivalry and use their political abilities to achieve broad organisational goals. Respondents argued a Clinical Director must:

*“...// have an ability to broker arrangements between various units in terms of competing demands...// At times, we all think that the area we have is the best and that we should all have priority ...//”*

The study participants proposed that the Clinical Director should have a level of political astuteness, along with the ability to look at health management issues from a clinical perspective. One Nursing Director 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..., we would be missing [an] opportunity from a political level. They bring political astuteness and [an] ability to ... tackle issues [at] a different level.”*

Whilst Clinical Directors are able to negotiate and persuade through their strong political base,<sup>30</sup> the difficulties of clinical directorship can be exacerbated by the presence of elitist cultures and powerful individuals within the medical profession. Skilful negotiation and peer management skills play an important role in “working the system”.

*“...// you need to be able to negotiate and to lead people to areas where they don't necessarily want to go...// they must know how to work the system...// they are very powerful and in this organisation, the medical staff wield huge amounts of power...// I think the business of running these large institutions is not fiscal or financial... it is*

*to do with people and how you control people's egos. Control is not the right word  
... manage their egos...//”*

Clinical Directors can be caught in the dilemma that exists between clinical representation and clinical leadership. The hardest challenge for a Clinical Director can be to choose between looking out for their peers and the broader interest of the organisation.<sup>31</sup> One Clinical Director noted:

*“You have to make decisions and stick to those decisions. Let your colleagues know why those decisions have been made (whether they are popular or not) and actually pull people together into a team to see what the aim of the organisation is.”*

### ***Clinical Experience***

It has been argued that clinical competence and an understanding of current clinical issues are crucial components to a Clinical Director building trust and credibility.<sup>30</sup> According to our data, a doctor will tend to accept decisions made by another practicing clinician over those made by others. Further, because they understand the clinical process, a Clinical Director can identify how management decisions impact upon quality of care. Respondents noted:

*“...// If they know that the person saying no to them is also a clinician currently practicing in the same organisation, then they are much more likely to accept it as being a valid and rational decision...// Clinicians are the people who understand what the clinical process actually is and how they can change it...//”*

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 and financial goals. The use of benchmarking, key performance indicators and accreditation are ways in which a Clinical Director can be shown to be effective:

*“... the ideal would be for everyone to operate on evidence based practice ...  
Nothing gets implemented unless there is ... solid evidence...// We have also made  
comparisons across a number of indicators with other like organisations across  
Australia as part of [a] benchmarking exercise...”*

Research also found that although managers and clinicians 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.<sup>32</sup>

### ***Peer Influence***

A Clinical Director must use their credibility and respect to balance the concerns of their medical colleagues with the needs of the organisation.<sup>31</sup> Our data support the position that respect plays an important role in both collegial and wider influence:

*“...// If they are highly respected as a Physician, then their peers are much more likely to take on board their recommendations or assertions...// 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...// They have to be prepared to stand up and actually contradict their colleagues at times...//”*

The degree to which a Clinical Director can influence their medical colleagues may be dependent upon how they manage the personalities 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. Making sometimes unpopular, organisationally focussed decisions that go against their medical colleagues' interests can be confronting. In such an environment, performance management can prove to be difficult.

*“...// you are dealing with very intelligent people ... who probably have a natural dislike of authority and control and probably hate bureaucrats...// has been likened to herding cat ...// doctors are egotistical bastards ... // when you performance manage doctors... you are doing it against criteria that don't involve their general clinical skills. It gets very hard... Medical staff are very powerful...//”*

One assumption behind the clinical directorate model is that it provides a structure for managing health professionals. The tenet of clinical freedom places substantial limitations on a Clinical Director's authority over their medical colleagues.<sup>3</sup> The special standing doctors have in hospitals may often subvert what is intended to be a managerial subordinate into a colleague, making managerial norms of accountability hard to apply.<sup>33</sup>

### ***Domain Characteristics and Development Requirements***

As Clinical Directors are commonly experienced medical practitioners there is the potential for them to embody the domain skills and characteristics that our respondents argued are required for effective management in the hospital environment. Nevertheless, our respondents were clear that there remained a deficiency in skills and hence developmental imperatives for efficient and effective performance. Figure 1 summarises the discussion, by highlighting the domain characteristics that Clinical Directors are thought to bring to a devolved management environment and the development needs that are perceived to promote success in their roles.

### **Business Skills**

Notwithstanding the strategic value of clinical skills for a Clinical Director, the study's participants perceived that Clinical Directors need a specific management skill set in order to be efficient and effective. In particular, it was perceived that they require skills in finance, strategic and human resources management.

### ***Financial Management Skills***

Successful budget management in the face of decreasing resources was considered to be a good indicator of Clinical Director efficiency. Clinical Directors with greater financial understanding are able to more easily challenge the financial agendas of managers.<sup>2</sup> However, the Western Australian experience is that many Clinical Directors tend to rely on the directorate's Business Manager to provide detailed financial analysis. This reliance is not ideal as a Clinical Director's clinical knowledge is significant in determining what reasonable levels of expenditure, activity and output are.<sup>20</sup> One Clinical Director observed that:

*“There is a tendency to leave the financial side to the Business Manager and I don't believe that is 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 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. Often the clinical conscience wins out.

*“...// I think that [our] effectiveness ... is constrained by the resources that [we] are given and I do think that we have a major problem in that area...// Efficiency is about setting priorities, working out what is negotiable and has to be done then balancing the rights of other people...// Do I sign the form and put my budget over? I don't hesitate...//”*

### ***Strategic Skills***

A Clinical Director must be an agent for change, initiator, objectivist, risk taker and persuader.<sup>31</sup>

Clinician leadership is important in that it defines what the future of healthcare should look like and aligns those involved with that vision:

*“...the requirements of a Clinical Director ... I think [are] strategic thinking, development of strategic policy and development of innovative methods of delivering care...// the ones that have a broad vision of ... health in general and can step from the operational realities of the directorate [in]to the strategic requirements of the role...// 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...//”*

A Job Description Form of a Clinical Director that was made available to the researchers supports this notion. The tasks outlined are for the most part strategic in nature. Terms that are used include “maintains and enhances...” and “promotes and fosters...”.

Before embarking upon strategic development, a Clinical Director must have a clear understanding of their role and the level of authority they have been delegated. One respondent observed that:

*“It’s all about authority. It’s about having delegated authority to commit resources. It is 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.”*

Clinical Directors often assume roles that are “ill-defined, inconsistent and ambiguous”.<sup>34</sup> In this study lack of delegation and the existence of parallel management structures was the major cause of frustration.

*“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...// Responsibility has never been devolved to the Clinical Directors... all these strings that were held on to and the parallel structure remains a problem...// there is devolvement clinically, but there is hardly any devolvement from a corporate point of view...// without delegated authority they’re very much just a mediator between competing requests...//”*

### ***Human Resource Management Skills***

It has been questioned whether conventional management tasks such as staff management are best use of a Clinical Director’s time.<sup>35</sup> However, the data suggest that insights into elements of human resource management such as staff utilisation, motivation and teamwork are extremely important. 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.

*“...// you can judge [effectiveness] by people wanting to come back and work here, [to] stay and not leave...// ...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...// [Its] about managing people, their expectations and difficulties, but managing in a way that makes sure there is a degree of harmony and common sense...//”*

The difficulty in managing professionals is highlighted by the traditional medical culture of ultimate responsibility for individual patients. Such a culture results in an organisation of “single players”.<sup>10</sup> Doctors’ poor team orientation and perceived superiority have been described in terms of an “occupational community”.<sup>23</sup> The challenge for a Clinical Director is to bring all individuals within the occupational community together into a cohesive team. Our data support the notion that team building through delegation (particularly to their management team) is an essential skill.

*“...// He is very happy to delegate responsibility. He is not a control freak as long as we keep him informed about the progress of things and go to him with issues and problems...// Each of us had different skills and experience and he accepted those ...If there was a nursing issue, he would be looking [to] the Nursing Director...//*

This study found that the relationship between a Clinical Director and their Nursing Director is of particular importance. As Clinical Directors are involved in their role on a part-time basis, they are often dependent upon the full-time presence of their Nursing Director. As one Nursing Director pointed out:

*“The Clinical Director identifies his vision, sets it..., runs it past me [and] I work with him. You see what [the vision] is, but I make it happen. 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...”*

Faced with departments and clinicians that have competing needs and thoughts of self-importance, the efficient Clinical Director must be able to clearly identify, prioritise and quickly



resolve personnel issues within their directorate. The data suggest, however, that Clinical Directors aren't necessarily the ones who want to be seen to be making those decisions.

*"...// Being able to problem solve when there [is] a problem. Dealing with interpersonal issues and how to handle day-to-day conflicts is important...// 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...//"*

### ***Business Characteristics and Development Requirements***

The following figure summarises our 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.

### **Personal Attributes**

The participants considered that Clinical Directors need intrapersonal (self-knowledge) skills and interpersonal (relational-context knowledge) skills in order to be efficient and effective.

### ***Intrapersonal Skills***

A Clinical Director's commitment to both their role and the organisation are essential contributors to their success:

*"...// they have to be enthusiastic about their role in administration...// I think if you are going to be good at it, you have to want to do it...//"*

Doctors are usually given one or two sessions (3.5–7 hours) per week to engage in management.

A number of respondents even suggested that Clinical Directors should be full time in their role.

"Achievement drive", the ability to manage and see projects through to completion and the determination to persist when challenged by obstacles<sup>20,30</sup> are dimensions of successful

directorship. The rewards can be satisfying, although frustrations born of the Western Australian context can test the persistence of Clinical Directors:

*“...// We have been given several opportunities to take some big projects forward because we have been able to demonstrate some success previously...// If there is continual ... frustration in the system, I think you will find [that] you [will] have less committed people ... take over these positions...//”*

### ***Interpersonal Skills***

In a hospital environment, collaboration can either be with individual staff, across specialty groups or across directorates. Interpersonal skill development is important to the Clinical Director, as the introduction of devolved management 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.”*

Clinical Directors spend a considerable amount of time communicating with others. Time is spent defining their role, determining expectations, building teams, communicating work requirements and clarifying values and beliefs. Whilst Clinical Directors may have difficulty in communicating some messages, communication and listening skills that encompass all levels of the organisation are essential for successful Clinical Directorship:

*“...// the ability to communicate very clearly to their peers at a very high level...// they need to be able to put their case forward in different forums ... they [could] be talking to people without a clinical background...// has been a very open communicator...// He has taken [issues to] the hospital executive, took from them and fed back...// to be able to listen and take an interest in the goings on...//doctors don't*

*like to deliver bad news to patients and we aren't really that good at delivering bad news to our colleagues...//”*

### ***Personal Attributes and Development Requirements***

The following figure summarises our discussion by highlighting the characteristics that effective 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.

### **Implications for Practice**

Successful Clinical Directorship requires competency across a number of important dimensions. Our emergent Clinical Director Efficiency and Effectiveness 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.

A model has been developed that closely relates to elements of our model.<sup>24</sup> Its categories cover contextual awareness, strategic thinking, functional and operational skills, interpersonal and team skills and self management. This consistency is corroborative of our results.

One of the problems most frequently cited with regard to directorate implementation is the lack of management training for doctors.<sup>21</sup> Our respondents were clear that to facilitate consistent efficient and effective management, attention to training is required. Our model provides a framework by which existing Clinical Directors can compare their skills and attributes and appropriately focused training and development programmes can be developed. By recognising the skills and attributes for successful Clinical Directorship, the model also provides a tool for identifying and recruiting doctors for executive responsibility.

The basic purpose of management is to ensure that “...an organisation’s goals are achieved in an efficient and effective manner”.<sup>36</sup> Being the two dimensions of performance, efficiency and effectiveness are often used as a measure of a manager’s success. To be efficient, a manager must utilise resources wisely in a cost-effective manner, whereas to be effective, a manager must make the right decisions and successfully implement them.

Measures of managerial efficiency in a hospital setting focus on clinical performance indicators such as patients treated per annum, number of bed days per patient or length of theatre waiting lists and on corporate indicators such as budget expenditure, staff turnover or cost per diagnostic related group. The measures of effectiveness include reductions in infection rates and repeat admissions, reductions in adverse events, patient satisfaction, introduction of new medical services or technology, or participating in cutting edge research. A hospital manager 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. It has been noted that in service industries such as health, where services are produced and consumed simultaneously, efficiency and effectiveness tend to be more subjectively determined than for industries that produce goods.<sup>37</sup>

Our data suggests that in the healthcare environment, doctors may be uniquely placed in the role of a Clinical Director to achieve a balance of effective clinical outcomes with efficiency in a resource constrained environment. The expectation of the combination of the managerial and professional in the position of the Clinical Director has been that doctors are able to bring unique clinical insights into hospital management. Their knowledge of the environment, understanding of the politics of healthcare, knowledge of clinical medicine, diagnosis and treatment and knowing how their peers think, are critical elements that are nearly impossible for non-clinical managers to bring to hospital management.

We have described the perceived dimensions of efficiency and effectiveness of a Clinical Director in the Western Australian context. It was found that domain knowledge and skills are the grounding for the effectiveness of the Clinical Director. Greater clinical input into the development and prioritisation of health service strategies is one of the most important advantages. Promotion of a team approach to service delivery and enhanced communication between clinical and management groups can also result from devolved management.

However, business skills and personal attributes are also important for the perceived efficiency and effectiveness of Clinical Directors. Although impressive, many of the benefits stated above are based upon an assumption. That assumption is, 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. Through our respondents, this study was able to identify the development needs of specific skills and knowledge that facilitate the effectiveness and efficiency of Clinical Directors.

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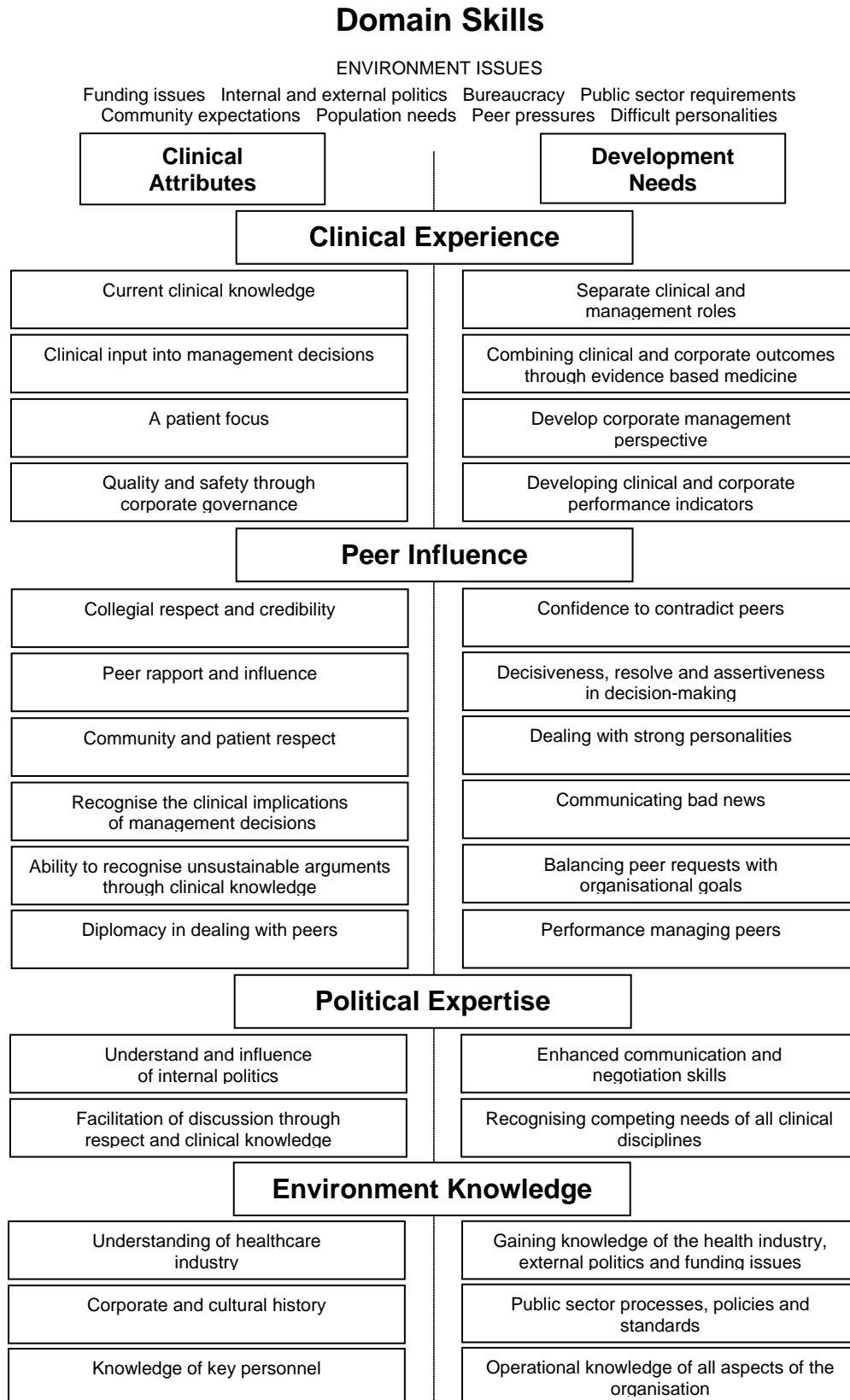
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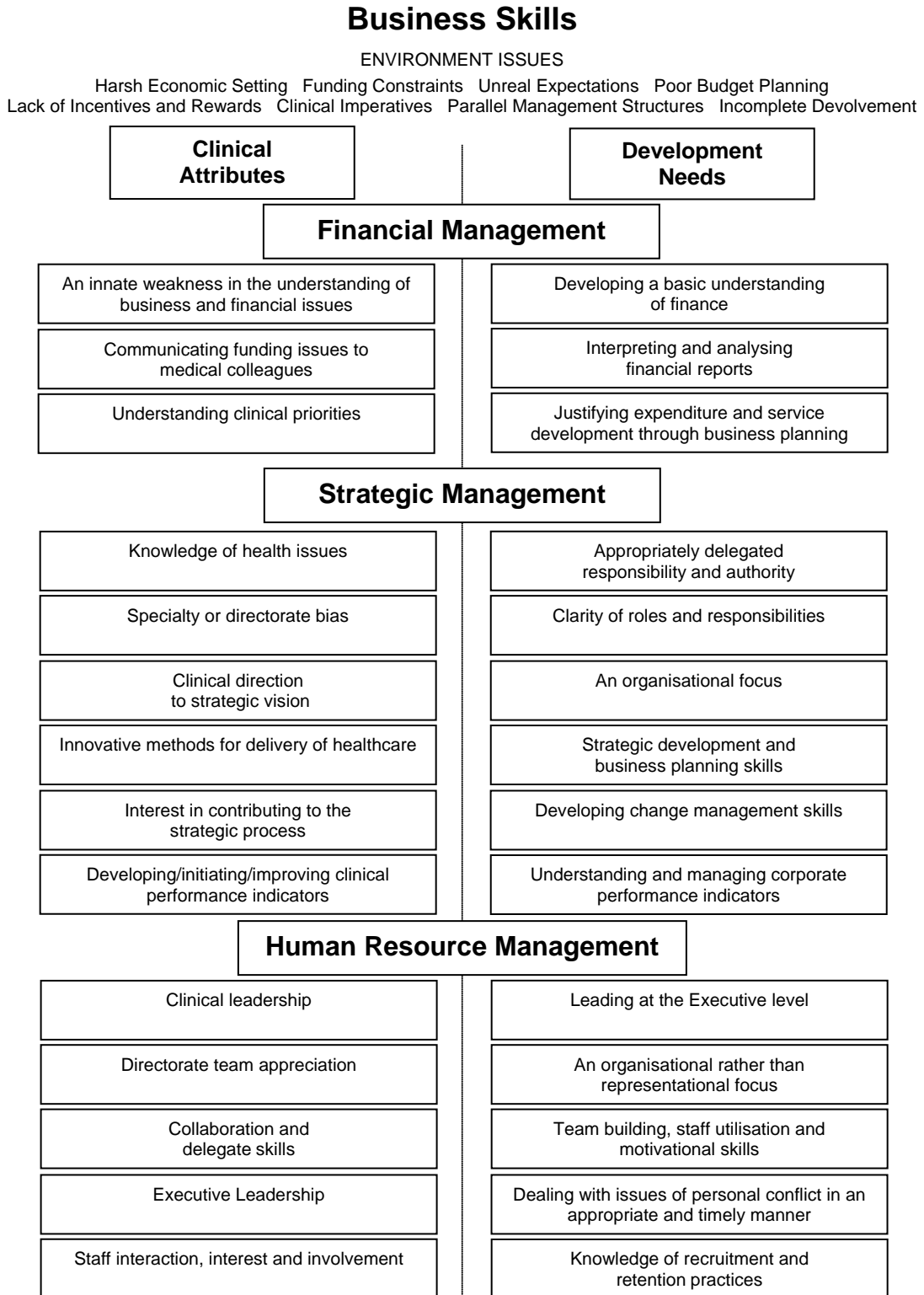
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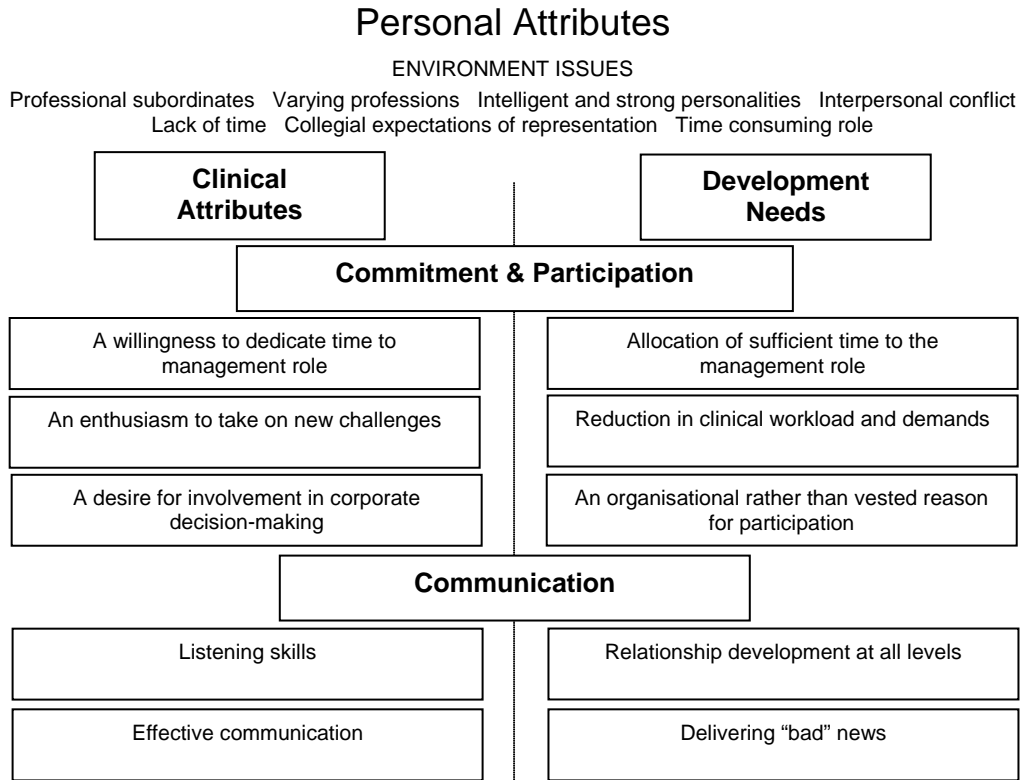
**Figure 1 Domain Characteristics and Development Requirements**



**Figure 2 Business Characteristics and Development Requirements**



**Figure 3 Personal Attributes and Development Requirements**



**Figure 4 The Emergent Model**

