

Transitioning from remote clinician to manager: Why do some managers thrive, yet others barely survive?



Pilot Project Report
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Introduction

Today, we live in a connected world. Globalisation, innovation, and automation have changed the nature of how and where we work. For the first time in history, less than half of the civilian Australian employed population have a permanent full-time job with leave entitlements (Carney & Stanford, 2018). Of those Australians employed, approximately 80% work in the service industry (ABS, 2016). Flexible work arrangements are increasingly more common in service industries (e.g. short-term contracts, work-from-home, casualised workforces, outsourcing, and 'gig' workers) (Carney & Stanford, 2018). As technology improves workforce mobility across the globe; innovation continues to drive flexible models of working. As a result, frontline managers are increasingly occupying hybrid roles where they retain professional responsibilities alongside their new managerial responsibilities. However, little is known about how to prepare for the competing priorities of a hybrid manager role (Martens, Motz & Stump, 2018). This pilot project examines the hybrid role of a clinician-manager in a geographically remote context to determine better ways of transitioning professionals into hybrid manager roles. The clinician-to-manager transition in a geographically remote context was chosen because it exemplifies the challenges of a remote nonconventional workforce, and the insecurity of flexible workforces.

Background

For most professionals, the transition into management occurs when a person is at the peak of their professional life. Thus, the career progression for most professionals is from technical expert to manager, and the health sector is no different. However, when the career progression includes a hybrid role the transition may be more challenging. For example, in the health sector where clinicians often transition into hybrid manager roles (hereafter 'clinician-managers') via unplanned pathways, they often find themselves as 'accidental' or 'reluctant' managers (Spehar, Frich & Kjekshus, 2015). For clinician-managers living and working in remote areas, these unplanned pathways are often a result of workforce shortages, high turnover and low retention.

Globally, organisations providing health services in geographically remote regions traditionally have high workforce turnover. For example, the average annual turnover rate for remote nurses in Australia's Northern Territory is 150% compared to 40% Australia-wide (Zhao et al., 2018). Similar high turnover is experienced in remote regions worldwide (WHO, 2010). Based on more than 25 years of research, the Gallup Organisation suggests that an organisation with a turnover problem has a manager problem (Buckingham & Coffman, 1999). An analysis of recruitment advertisements for management positions in remote northern Australia in 2013-2015, revealed that many health service organisations may be contributing to the presence of unprepared managers (Onnis, 2014; 2016). According to the study, many health services organisations do not seek candidates with management qualifications and/or relevant

experience when recruiting managers (Onnis, 2014; 2016). Onnis (2016) found that management qualifications were mandatory in 4% and desirable in 9.5% of advertisements; and that management experience was mandatory in only 5.5% and desirable in 0.8% of the recruitment advertisements for managers to work in geographically remote health services.

Moreover, the challenges are often exacerbated by geographic isolation, reduced access to professional development and an absence of support in developing the mindset and skills that underpin good management practices (Onnis, 2014). Often clinician-managers are unaware that being effective in a managerial role requires different skills to their professional role. The clinician-to-manager transition is an excellent example of role tension; where many hybrid managers prioritise professional responsibilities over managerial activities. Therefore, management development is vital because the skills and qualities that make an excellent clinician are not the same as those that make an excellent manager.

In the grey literature, clinician-managers describe their experiences of role ambiguity and being unprepared for the transition into their managerial role. These articles are informative, but largely descriptive (Spehar, Frich & Kjekshus, 2015). In fact, research that goes beyond describing the experience of clinician-to-manager transition is scarce, particularly in settings other than urban hospitals. Further, few studies have investigated the influences of roles and work contexts conducive to developing successful hybrid managers. Thus, the literature reveals that there is a need for further research about hybrid manager roles and the transition into such roles (Spehar, Frich & Kjekshus, 2015).

Furthermore, most of the current research about clinician-managers is from Europe, with only a few Australian studies; the majority of which focus on urban hospital-based clinician-managers (Fulop, 2012; Fulop & Day, 2010; Kippist & Fitzgerald, 2009; Spehar, Frich & Kjekshus, 2015; Thompson & Henwood, 2016). The changing nature of health services in Australia means that clinician-managers are not necessarily hospital-based with many working in community health services (National Rural Health Alliance, 2004; Thompson & Henwood, 2016). As a result, the current hospital-based research does not address the challenges for community health services or the nuances of remoteness. In the past what has worked in an urban hospital has not always worked in the remote context. Taking an alternative view, the author of this report proposes that research that considers the nuances of remoteness can more readily be adapted to urban settings where there are remote workers.

Clinician-managers

As mentioned previously, the clinician-to-manager transition in a geographically remote context exemplifies the challenges of managing remote nonconventional workforces,

including the challenges for hybrid managers who have both managerial and clinical responsibilities (hereafter 'clinician-managers'). The clinician-manager has two distinct roles despite usually being considered one role. Clinician-managers are nurses, doctors, or allied health professionals (e.g. psychologists, physiotherapists) whose work activities are divided between a management and a clinical role (National Rural Health Alliance, 2004). Clinician-managers differ from Health Service Managers, with the latter spending 100% of their time engaged in management duties. For clinician-managers the hybrid role means balancing clinical and management responsibilities, which usually means that their clinical responsibilities prevail (Onnis, 2014; Thompson & Henwood, 2016). When considered in a context of workforce shortages, high turnover, poor retention, demanding workloads and isolation; this is a high risk environment for an inexperienced manager. However, this is a real scenario for many clinicians who are prematurely promoted into clinician-manager roles (National Rural Health Alliance, 2004; Onnis, 2019; Thompson & Henwood, 2016). It is a scenario in which they live and work with minimal management training and often with inadequate support (Onnis, 2014; Thompson & Henwood, 2016). For clinician-managers, support is vital because the skills and qualities that make good clinicians are different to those that make good managers (National Rural Health Alliance, 2004; Spehar, Frich & Kjekshus, 2015).

Spehar, Frich and Kjekshus (2015) suggested a need for research to understand why some clinicians succeed and others fail in the role of clinician-manager. Therefore, previous research has identified a need for improved understanding of the hybrid manager role transition; and an improved understanding of the benefit of quality improvement approaches in evaluating real-world benefits of management development initiatives (Onnis, 2014; Onnis, Hakendorf & Tsey, 2018). The reasons why some people thrive in clinician-manager roles in remote Australia while others do not is unknown, yet important given high turnover and increasing demands on clinician-managers to provide quality health services (Onnis & Pryce, 2016).

Aim and research questions

This study builds on research investigating remote health workforce sustainability in northern Australia. Previous research revealed the need to support clinician-managers in remote contexts to develop good management practices in order to improve workforce sustainability (Onnis, 2015; 2016; 2019). Building on these findings, a scoping literature review revealed that CQI is beneficial, but not widely used in evaluating management development programs (Onnis, Hakendorf & Tsey, 2018). Further, research evaluating a customised remote management development program suggested that CQI action learning activities provide practical support in applying management skills in remote contexts (Onnis, Hakendorf, Diamond & Tsey, 2019). Hence, this project is responding to the need to understand more about the clinicians who thrive after transitioning into

clinician-manager roles. This study contributes to the literature about suitable ways of supporting the clinician-manager transition in remote health service contexts.

The aim of the pilot study is to investigate the transition from clinician to manager to improve our understanding about why some clinicians thrive as clinician managers in remote areas, while others do not. These findings will be used to better support transitioning managers, and to inform health services and educational institutions. Further, the insights from the pilot study will shape the design of future research in this area.

The research questions were:

- 1) What are the barriers and enablers for success during the clinician-to-manager transition?
- 2) How effective is this research design to investigate this type of real-world issue?

Methods

The pilot study used a qualitative, exploratory research design. The study investigated the clinician-to-manager transition with clinician-managers working in remote areas of Far North Queensland to learn more about the experience. In particular, the study focused on the transition (their story), support seeking behaviours (how and where they sought assistance), what was helpful and how they could have been better supported to develop the necessary management skills and practices.

Sampling

A stratified purposive sampling method was used to recruit clinician-managers working in remote areas of Far North Queensland (FNQ). Participants were invited to participate in the pilot study through an invitation describing the research study in CRANApplus' regular weekly email to members, the *CRANApulse*, from January to March 2019. Two versions of the invitation appeared over the two month period; however, this method of communication did not attract any suitable participants. The contingency plan was enacted and four participants were recruited through a word of mouth snowball method of recruitment until a small sample of four participants were recruited. The participants worked in a clinical role prior to commencing as a clinician-manager, and were working in a geographically remote area in FNQ during the clinician-to-manager transition.

Participation was voluntary. The participants were screened to ensure that they met the criteria for inclusion in the pilot study:

- 1) worked in FNQ
- 2) held a hybrid manager position in remote Australia
- 3) worked in a clinical role prior to the commencing the manager role;

- 4) willing and available to participate in the research activities (interviews, reflective discussions, management development activities).

The study sought an ideal sample encouraging diversity and broad representation by seeking male, female, Indigenous, and non-Indigenous participants, as well as participants from non-english speaking backgrounds. A gender-balanced sample was not achieved due to the high proportion of females in clinician-manager roles in the region and the voluntary nature of participation. Further, the study did not attract any Indigenous people or people from non-English speaking backgrounds as participants which is noted, along with the lack of gender-balance, as a limitation in this study. As the ideal sample was not possible, the study proceeded with the best possible alternative sample which comprised four female participants who were fairly representative of the clinician-manager population.

Data collection

The data collection occurred during arranged *contacts* with participants over a six month period (see Figure 1). The first and last contact was an informal interview, while the three interim contacts were informal reflective mentoring-type discussions. The interviews and reflective discussions were recorded and the audio was transcribed.

Interview 1 (approximately 60 minutes)

A typical interview included: background information, professional/personal goals, qualifications, professional experience, their story about how and why they became a clinician-manager, challenges, barriers and enablers, how and where they sought assistance, what worked, what do they know now that they wished that they knew earlier that would have helped the transition, and what advice would they offer to a clinician transitioning into a management role to help them in the early days.

Reflective Discussions (30-60 minutes)

The reflective discussions were mentoring style discussions where the researcher guided the participant through a reflective process about their current management role, management style, current challenges, sources of assistance and any other aspects of management that the participant wanted to discuss. The PAR approach supported the manager in developing (or refining) their reflective practice skills and the 'miracle question' was used to assist them in identifying actions that they could take to improve their effectiveness as a manager. In this study, the miracle question was:

If a miracle occurred last night and when you walked into work this morning everything was just how you would like it to be - what would it look like?
How is that different to what it looked like when you came into work this morning?

Interview 2 (approximately 60 minutes)

In the final interview the researcher and participant reflected on the research process, and the resources provided (or suggested) to professionally/personally support the participant. The participant and the researcher discussed the strengths and weaknesses of the research approach and how it can be improved to better benefit remote clinician-managers and health services.

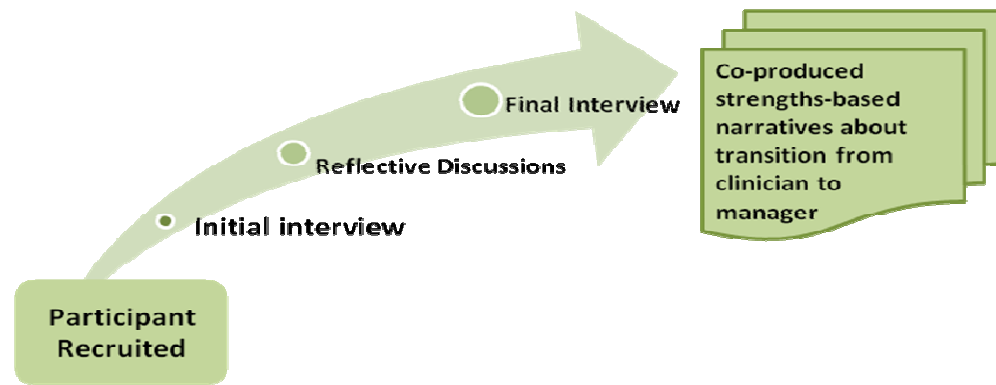


Figure 1: Research Design

Data analysis

A thematic analysis of the transcripts was conducted using NVivo12. The data was non-identifiable and the findings for each participant were considered to be a case. The findings across cases were synthesised to reveal what can be learned from the pilot study about the transition from clinician to manager. While the sample is too small to draw conclusions about the transition from clinician to manager, the study contributes to our understanding of the barriers and enablers for remote clinician-managers and will inform the design of future studies.

Participants

The four clinician-managers who participated in the pilot study transitioned from clinician to clinician-manager in a remote community or town in Far North Queensland. Three of the clinician-managers transitioned into the management role with at least ten years experience as a clinician (two in nursing, one in allied health) and the fourth transitioned into a clinician-manager role with less than five years clinical experience in nursing. All four clinician-managers participated in the first interview, two participated in the entire pilot study process over the six month period (initial interview, two or three reflective discussions, and final interview); one clinician-manager only participated in the initial interview and the fourth participated in the first and final interviews.

Barriers and Enablers

In the first interviews, the participants identified the barriers and enablers of a successful clinician-to-manager transition. The four key areas identified were:

preparation and training for the role; support (from their manager and their team); clinical/managerial role conflict; and the work environment. Each key area was identified as being either a barrier or an enabler for a successful clinician-to-manager transition depending on whether it was absent or whether it was adequately addressed by the remote health service and/or the remote clinician-manager. The key areas identified were consistent with the findings of other studies (Fulop & Day, 2010; Lenthall et al., 2011; Onnis & Dyer, 2017; Spehar et al., 2012; Thompson & Henwood, 2016)

This study piloted a research method where the researcher and each of the participants reflected on each manager's transition in real-time. That is, through a series of contacts over a six month period the researcher and each participant discussed and reflected on the challenges, what was going well and where improvements could be made including personal and professional development opportunities. During these reflective sessions, additional barriers and enablers emerged, many of which provided an insight into the transition that may not have been revealed through a single one-off interview with each participant.

Overall, an analysis of the data from the interviews and reflective discussions identified eight barriers and enablers: preparation, assistance-seeking; support, role clarity, setting boundaries, work environment, personal characteristics, and self-care (see Table 1).

Preparation

In this study, one participant had a pathway to management that was more planned than the other three; however, in the initial interviews they all found that the transition into the clinician-manager role lacked the necessary preparation. One participant said that when she asked about a handover, the supervisor 'just laughed at me and said "Oh, you'll just have to wing it like the rest of us".' This lack of preparation for health professionals commencing in management roles has been previously recognised (Fulop & Day, 2010; Spehar et al., 2012). One of the participants explained that initially, 'you don't know what you don't know' but over time they worked out how to access the training they needed. Accessing training usually involved travel to a regional centre or a larger town. Though not initially recognised, during the reflective discussions one manager acknowledged that the training provided by her previous employer may have been more beneficial than she had first thought saying, 'even the operations manager didn't know a lot of the things that I knew so, yeah, I don't know, maybe [previous employer] did give me more education than I thought or training.' Therefore, the lack of understanding about what is required may have influenced their opinion about whether or not they had received adequate preparation and training.

The participants emphasised that orientation and an adequate handover were areas that could be improved if the clinician-to-manager transition is to be smoother. All of

the participants emphasised the challenges with handover, saying that often the previous clinician-manager left abruptly, took personal leave before going, or the position had been filled by a series of short-term incumbents – all of which result in the new clinician-manager not having an opportunity to meet the previous clinician-manager for a handover. As a result, they often walked into a work environment where everyone was working above or beyond a capacity that could be maintained long-term.

Assistance-seeking

Most of the clinician–managers were aware of the areas where they needed additional knowledge, which were usually with systems and documentation (e.g. payroll forms). While some went directly to the associated corporate services department; others sourced assistance and guidance from their peers. One participant said ‘I read management books and also went to HR’, others already had contacts in corporate services and several of the participants were doing tertiary management studies or had management subjects in their previous courses (e.g. Health Management is a subject in the Masters of Public Health).

One participant reflected on the experience of a colleague and how this was impacting her current role. While she was empathetic to their situation, she said that their attitude before starting was ambitious (i.e. they said that they were going to be much better than the former manager). However, this was not what happened. Since commencing they had contacted her almost every day asking questions about basic operational tasks. She felt obligated to help the new clinician-manager but did not want them to depend on her for solutions to their problems. So she started to teach them, saying “if you don't know that, what I would do is call payroll to find out” or “look at the form on this page.” She said “a lot of people do not use their initiative to seek out information or to answer their own questions.” Other participants also commented on the lack of initiative they had observed in others. In contrast, one participant described it from the point of view of an ill-prepared clinician-manager with expectations that it was someone else’s responsibility to train them on-the-job saying, ‘there was nobody saying to me this is what you might need to learn, this is where you will find your financial accountabilities, recurrent/non-recurrent, what it all means. Nobody was there, nobody was actually teaching me anything’ she went on to say ‘If I asked a question about budget I’d be sent to the Finance Department ... nobody was prepared to mentor me ... [when] you’ve come from a clinician ... there is going to be a transition. So my line manager didn't do any of that.’

Management, peer and team support

According to all participants, support from both their line manager and their team, was vital for a successful clinician-to-manager transition. Some of the participants, transitioned from clinical team member to the clinician-manager of that same team

which created challenges as they commenced managing people who were formerly peers. For two of the participants, one of their first tasks was to recruit someone to replace themselves, so they were under resourced from the start and could not reduce their clinical work until they had recruited a new clinician. One participant explained, 'Doing the clinical [work] plus trying to get the handover from the team leader and then the transition ... I'm in the team leader job but I'm still finishing my clinical [work] to handover.' In contrast another participant found that their team were part of their support system, saying:

I think what's been going well is this team ... I've got a case load and I'm having a bad week. We've all kind of really pulled together about it ... people were saying well I can do this ... It was nice, it was a nice feeling and it was a completely different feeling than you'd have with a stressful workload if you didn't have a good team. So yeah it was nice. I think that's one thing that's going well and is continuing to benefit me on a daily basis.

All of the participants described the impact of secondments, temporary and short-term appointments, and movement within the remote health service organisation and the region; all of which contributed to workforce instability, and reduced their access to support. However, the participants had different experiences with the level and type of support they were receiving from their line managers. One participant found her manager to be very supportive, especially when she was very busy, saying "my manager, she's really good and usually I work really, really well with her and she says to me how can I help?" The clinician-managers said that their managers sometimes offered practical solutions such as assistance from an Administration Assistant with some of the more administrative aspects of their role. However, not all of the clinician-managers felt that they received sufficient management support with one saying, 'I'm really quite vocal about it ... I'm not moaning about it but I'm certainly letting them know ... I document it in my reports ... I feel it just falls on deaf ears.' One clinician-manager explained that their line manager, despite knowing how busy the clinician-manager was at the time, often added to their stress, saying:

I've got active clients, I'm really busy but then I'll get 10 emails that week saying can you please review this, can you just have a look at this [document] ... I haven't got time for this, you can't send me this and say it needs to be done in two days ... it adds to your stress.

The participants highlighted how they were impacted by the high turnover typical of remote areas. Where there is high turnover, people may be prematurely promoted and unable to manage the demands of the role, or those showing competence are quickly promoted to more senior roles (Pluchino, Rapisarda & Garofalo, 2010). This creates further challenges for new clinician-managers with one participant describing her

situation, saying she was told, 'You'll get all the support you need.' However, the environment changed, she said 'as soon as I took that job ... the manager got a secondment, and then obviously [someone else] then stepped in and after a month ... he stepped out.' This rapid turnover meant that she did not receive the support she had anticipated from her line manager. Management in Practice 1 demonstrates how reflective practice can assist a clinician-manager to find the support that they need.

Management in Practice 1: Support networks

'I think the one thing that isn't going so well is my relationship with my manager ... I've reached out for support ... and just got none and it's made me quite angry because I've got an expectation that I would get support.' In the next reflective meeting she said that she had spoken with her manager again but this time, 'I didn't have any expectation I would get any support so it didn't bother me and that was part of the reflection ... first when I rang and I was really overwhelmed and said I need some help ... I had expectations at that time that I was really going to get some support and in hindsight that was why I felt angry and upset ... I probably should have gone to somebody for a more personal supervision because that's what I was seeking at the time. I wasn't expecting a practical solution what I was hoping for is just somebody to say, "Are you okay?"'

Where clinician-managers were able to reflect on their experiences, they were able to find their own solutions as Management in Practice 1 suggests, clinician-managers may need a network of people who support them in different ways. For one participant, knowing that her manager was just acting in the position, and that a new manager would start soon, helped her to get through a difficult period, hoping that better support was coming soon.

For clinician-managers, support from management significantly influences their success. One participant experiencing with self-doubt, and at times struggling with the immense workload, described a conversation that she had with her manager. It highlighted the significance of positive messages in encouraging new managers and also the need for clearer, more frequent communication. The participant said:

[My manager said] "you must think you're doing a good job." And I said "no". And she said "well you are doing a good job ... I don't know why you would think that you're not. You are doing a good job" ... She was so surprised to hear that I didn't think I was doing a good job. She said I'm doing a good job, but I'm not sure what that actually means.

Finally, peer support appears to be an enabler. One clinician-manager had regular meetings with her peers, usually by telephone although they did meet face-to-face when

possible. The main benefit they described was the opportunity to build relationships with their peers who were going through similar challenges. Some participants thought that when their manager was in the meetings that they weren't 'getting the best out of it, people aren't really speaking up'. It appears that when a manager is unable to support the managers who report to them (i.e. clinician-managers) it not only influences the manager-line manager relationship, it can potentially influence the peer relationships for the clinician-managers too.

The absence of role models amongst peers was a barrier for clinician-managers who would benefit from having someone on whom to model their management and leadership style early in their career. One participant explained that she thought that she could be a better manager if she did not have the clinical component of her role; however, she had said earlier in the discussion that a nurse from her team had said to her 'you get your hands a lot dirtier than any other manager we've had.' She reflected on the comment and said, 'there's absolutely no way I could say no to doing clinical work right now.' This suggested that she was doing more clinical work than previous clinician-managers and may have benefitted from mentoring about how to work towards a better balance. When asked about role models to help her to find the balance she did not feel that she had access to a good role model. It is not possible for this study to understand whether there was an absence of role models or whether this comment reflected a personal opinion; however, an absence of mentors and role models was consistently reported throughout the study.

All four participants mentioned the benefits of mentoring, with one saying 'I think that you get worn down if you don't have the support.' Two participants described the support that they had received as being helpful and mentioned people that they considered to be informal mentors and role models. While no-one had a formal mentoring arrangement in place for their management development, they all commented on the need to have someone when you are working in remote settings because you cannot talk to your team about it, so it can be very isolating.

Role clarity

Several studies have described the challenges of balancing the clinical and managerial responsibilities for the hybrid clinician-manager role (Fulop, 2012; Spehar et al., 2015). Building on published findings, other studies have also examined leadership and the hybrid role (Fulop & Day, 2010). As contemporary employment practices continue to move towards more flexible and insecure employment arrangements, the importance of role clarity and accessible contextualised resources prior to the onset of managerial difficulties increases (Di Fabio & Kenny, 2019).

In the pilot study, participants felt that there was no clear understanding about the expectations of their senior managers regarding how they were to allocate their time between managerial and clinical duties, with one participant saying, that it is not clear 'what percentage should be clinical and what percentage is non-clinical so this is really tricky.' This was further complicated when their line manager was not familiar with their work environment, and did not grasp the challenges of living and working 24 hours a day, seven days a week in a remote community with the team, and clients. However, it was quite clear that all of the participants put the clinical needs of their clients first (Thompson & Henwood, 2016), with one saying the 'clinical stuff always comes first realistically because that's why we do our jobs.'

The role tension was one aspect of the clinician-manager responsibilities that had a significant impact on their available time, and potentially on their health and wellbeing. As one clinician explained:

When you asked me about workload and I was like oh yeah I put all the team first and I realised that actually I put myself last sometimes and so I did do a bit of reflection on that ... one of the most important things that remote managers need to do is look after themselves so they don't burn out.

Some clinician-managers focused on the short-term and picked up the additional clinical work as part of their role. Others recognised that it was not sustainable, and applied a management mindset in looking for solutions. The more realistic their expectations about what they and their team can provide with the given resources the more likely it is that sustainable solutions are sought and implemented. As one clinician-manager explained in using the miracle question she moved from feeling overwhelmed by the workload to thinking about solutions:

I've tried to translate that too through my wants and needs. So, for instance I want another clinician because our workload is much heavier than anywhere else ... I thought well I need to think differently about how I approach this. So I started thinking about risk and workload management and ... I don't care if it takes two years there must be some planning, let's start gathering the data now, let's take a longer-term view ... as soon as I started gathering the data and putting the forms together they've moved a position from another area ... I think that we can complain ... but unless you can put it together in a way that you can build a case then nothing really changes ... I thought well now I'm going to take a longer term view and actually it's happened quite quickly.

For this participant, she not only stepped out of the problem into a space where she could seek a solution; she started to think and act more like a manager rather than a clinician. In making a business case rather than complaining, she saw how to lead her team into a better work environment, and over the following weeks she exhibited more of these managerial behaviours as she managed issues.

Management in Practice 2: Realistic Expectations

For new managers it can be difficult to know where to focus their energy. This is particularly difficult when balancing both clinical and managerial responsibilities and often they spend the majority of their time 'doing' rather than 'managing.' For one new clinician in a particularly difficult situation, where there were multiple long-term vacancies and several staff on leave she saw no alternative other than to take on many clinical activities. She communicated with the team in person and by email to manage expectations.

She said 'I sent an email to my boss and the whole team.' In the email she said that the 'clinical work comes first so I will obviously do my best to get to the other but I'm not going to be prioritising any of the team leader stuff or the paperwork and things because I have to make sure that the patients are getting their care ... that's happening over and above the other stuff.'

She reflected on her situation and explained, 'The clinical work a hundred percent always comes first. Definitely. But then you think about pays ... it's unfair if someone doesn't get paid because I haven't signed or submitted a form.' This weighed heavily on her because from day one she had implemented quite a few changes to improve systems and processes, while also carrying a case load and operating with staff shortages. She had managed to make some improvements; however, there were changes that she was unable to implement for reasons that were beyond her control. Earlier in our discussion she said 'nobody did all of this and I am doing all of it.' Yet, she was still disappointed with her progress in setting up systems and processes.

When asked if she thought that her expectations were too high for what can actually be achieved. She responded with, 'No. I probably just need to use my time more wisely ... I wish I could just be focused the whole time but I always get distracted or I end up having chit chats with the staff about stuff. Which is important, I know that that has its own important role but if I was 100 percent focused on task the whole time I could probably do what I needed to do. And I know that that's, I don't know if that is unrealistic but I can definitely work on being more focused more of the time.'

When asked 'Is that humanly possible?' She responded, 'It's probably not humanly possible to be 100 percent focused 100 percent of the time but I definitely could be more focused, more of the time.'

This is typical of the stories told by the clinician-managers and exemplifies the high expectations they have about what they can achieve in remote communities. Some of these managers were very task focused and the more stressed they appeared to be, the more they focused on 'doing more'. As a manager she continued to focus on the 'doing' and overlooked the importance of talking with staff to develop the very relationships that could help to improve

the work environment. In prioritising clients she may have made her team feel that their needs were not important to her, which may have affected their expectations about how their manager was meeting their needs as clinicians.

There was only one manager who appeared to have taken the time to step back to see that if she focused on managing one or two of the higher order issues at that higher level, she could problem solve without trying to simply work more hours each day. For this clinician-manager once she began to operate with a manager's mindset, she said that she changed, 'the way that I ask for things and that's been a bit more helpful. So I've actually managed to get an extra FTE ... things are really positive and yeah the teams just coming along really nicely. I think every day I feel quite proud of what's happening. And that's nice.'

The different approaches described in Management in Practice 2 stem from the varied level of management training and preparation for the role, and previous experiences including how they have seen clinician-managers address such challenges in the past. Also, the type of support they are receiving from their manager, team and peers, and to some extent, their personal characteristics shaped their approach and possibly whether they considered themselves to be thriving in their work environment.

Setting boundaries

Being able to set boundaries was important for each clinician-manager and it shaped the way they managed the tension with the clinical and managerial duties. All the clinician-managers described this and most explained how they set their boundaries; however, for some it was difficult to maintain these boundaries when they faced extreme pressures, and as a result, clinical duties consumed a lot of their time. It was evident that this could be an ongoing challenge for some clinician-managers. The following is an example that exemplifies the challenge for new clinician-managers. Despite each clinician-manager having their own approach it was clear that remoteness, and the associated challenges of remoteness, such as high turnover, added to the role tension.

Management in Practice 3: Establishing boundaries early

At one of the first meetings she set and communicated the boundaries saying 'I'm happy to be available to help out with clinical stuff or give an injection if there [are] no other nurses around ... but I do not have capacity to take on any clients as case manager. That is not my role ... I won't be doing that'. This clinician-manager purposefully set the boundaries in a pre-emptive manner. She explained, 'I can say "no", because they have already been prefaced with that.' In other words, she knew that she sometimes found it hard to say 'No', so she has proactively stated that she would not have a caseload, and then would remind staff of that if needed to ensure that she did not carry a

caseload freeing up her time to complete her managerial duties and cover clinical duties where needed. She used forethought and had a plan in place should the situation arise.

As the study progressed she started talking about the clinical work she had undertaken in the past week. When asked about why she did the clinical work she said, 'Because there was no one else to do it and ... to keep it smooth, keep the team running along so the doctor didn't run late, so the patient didn't miss their appointment.' She said that she could have put her foot down and insisted that one of the team went down to do it but thought that was 'a risky move when you're first up.' By first up, she meant new to managing the team. She went on to explain 'I think sometimes it hard for staff to understand what management does ... when you're sitting in your office typing away ... if you don't have that background knowledge it sort of just seems like your manager is just sitting in their office not doing anything super pertinent.'

This behaviour was partially consistent with the boundaries she set where she said that she would help out; and may have been part of an effort to demonstrate that she was clinically competent and willing to contribute to the team's success. However, in the broader context of her workload and her transition, it was not positively contributing to her establishing herself as the clinician-manager. She began to undermine her own position as she appeared to not maintain the boundaries she set initially. Then, in a reflective discussion she said, 'at the moment I've got a case load because we're so short staffed.' At the time she was *very* short-staffed; she had several staff on leave, long-term vacancies and was unable to backfill due to funding restrictions. During this period, only pressing aspects of her managerial duties were being addressed and she was unable to maintain the balance despite planning for such a situation.

Management in Practice 3 exemplified the challenges for the new clinician-manager. Based on the experiences of other clinician-managers in the pilot study, it is not a reflection on the clinician-manager per se, it is the result of a new clinician-manager, learning how to manage a diverse team, in a rural and remote area with inadequate support and resources. It was not uncommon. Another participant explained that they found themselves in a similar situation saying, 'I was quite anxious all the time because I couldn't fill shifts. I'd work late ... did on-call ... and be up half the night and then be a [manager] the next day and not get paid any overtime.' One participant described what she thought needed to happen, although she was not able to do it at the time of the reflective discussion:

Obviously clinicians are hands on, team leader one hand on one hand off, managers hands off ... the only way to make yourself [do the non-clinical work] and manage that time is to not open the office on the day that you definitely need to get [non-clinical work done] ... [you need to] not be in the office where people will bang on the window ... you have to manage that time really well because otherwise people end up doing what everybody else does ... working long hours into the night and people are still banging on the window. In remote everybody needs something ... so it's about being smart around your time.

Work environment

High turnover and workforce instability increased the number of people in each organisation who were new and were learning their own jobs, which added further pressure for new clinician-managers, especially in navigating systems, processes, networks and relationships. As one participant explained, 'It was like I was managing all of them, let alone the system. I couldn't get it done.' The participants thought that the transition would have been smoother if they could have chosen their own administrative support people, and had HR people more familiar with the remote context and the organisation's policies and systems at their disposal. However, the participants suggested that these challenges were a broader health service issue and not necessarily just about their understanding of the remote context. As a result, the isolation made clinician-managers feel that they were, as one participant explained, 'dragged into this stuff that wasn't even mine' when seeking assistance. Similarly, another said that 'if there's a policy or procedure I will follow that and then I will always go back to, well this is what the policy says and this is what we should be doing' but where policy was absent they depended on their own communication skills in trying to seek clarification about processes and systems from other areas of the organisation.

The remote context necessitates effective communication because there is reduced in-person contact with other team members and line managers. The participants emphasised the benefits of regular ongoing meetings with line managers and the team, and the importance of trust where there was an absence of daily contact due to the vast distances over which the health service operated. Also, orientation and an adequate handover were highlighted as areas that could be improved if the clinician-to-manager transition is to be smoother. One participant, having previously worked short-term in a clinician-manager role in a remote community described how much easier it was to transition into a clinician-manager role in FNQ. She said, 'it is different ... there were two factors, one is [previous team leader] had been there ... adding a lot of processes and it was running [well] ... the key other factor was that there was an amazing Administrator ... 80% of the role was just administration and she had all of that running smoothly.' So, they were completely different experiences. The first time, an exhausted clinician-

manager took sick leave and then did not return so she found herself walking into the office with paperwork 'flowing out of the drawers.' Whereas the second time, the previous clinician-manager had been there to handover, and everything was running effectively making for a smoother transition.

Personal characteristics

Personal characteristics influence the clinician-to-manager transition in several ways, including the way that clinician-managers respond to similar situations. One manager caught in a dire situation with inadequate resources took the extra work on herself, another successfully used a similar situation to plead the case for additional resources, and a third decided to 'lean in' to existing resources by sharing the additional load with the team. It appears that the responses were reflective of the personal characteristics of each manager, including past experience, and stress management strategies. Some participants were responding to challenges by putting in more time, with one saying 'I've been staying back quite late trying to fix stuff up' and 'it's just so much easier for me to just do it myself.' Most of the participants mentioned lists during the study, saying 'my to do list is massive'; 'it's about recognising that the list is endless really. I can just pick a couple of things on it each day; and another talking about their approach, saying:

I don't have a particular system. I love lists. I'll make a list every morning, I've got a master list ... And then even with the best list and the best plan and the best diary people come into my office on a constant basis and ask questions, or this has come up or the phone rings. So you just juggle it really.

One of the participants described a process she went through to manage a situation that she initially thought would involve a difficult conversation and performance management. By seeking resources and planning her approach she found that she had a role in creating the changes that she wanted to see in the workplace and by the end of the process had a very different view of the issue and how to manage it. Her positive mindset resulted in this process leading to a valuable learning experience. She said,

I pulled up some questions about prompts to have a challenging conversation with a staff member who [was] under-performing and I thought oh this is going to be lovely. I've got plenty of questions I can ask them ... [but] the first 15 were for me ... it was such a useful process because I went through them all ... it allowed us to set some processes out ... without having to just go down that performance management route ... it's not completely fixed but I think that I can now move forward where I have set up those expectations ... And I think that's saved a lot of time it's possibly avoided [an unpleasant] process, [and] it's been a really good learning curve for me.

Another one of the participants reflected on her difficulty in saying 'no' to people which was impacting her workload, her ability to balance her clinical and managerial responsibilities, and manage her time. She said, 'I did an assessment ... which I shouldn't have done ... so I've definitely been saying yes to some things that I potentially should be saying no to while I'm trying to catch up ... I just I struggle to say no.' The participants had an opportunity to select a people management issue that they wanted to work on improving for the research study. During the study the clinician-managers realised that what they needed to do was change their approach, their mindset, or something that they were doing to start the change process.

Self-care

Some of the managers described ways in which those around them were signalling their concern about the volume of work that they were doing and toll it was taking on them personally. One was using all the tools and resources available to her and was so inundated with work and responsibility she was finding ways of working for more hours each day, saying:

[T]his is probably not recommended ... but I've organised remote access so now I can work from home. So, I can try and catch up the non-clinical stuff at home and then that reduces the pressure a bit in the interim while I'm at work.

Another participant acknowledged that self-care was not something she did well saying, 'self care and making time for [me]. That's probably something I don't always do but it's on my radar that I need to [take leave].' Another participant also talked about the importance of leave saying, 'My leave has been on that list to do each morning but then it has to be shelved because you think well I can't prioritise my leave ... I think sometimes that's something that I could improve.' One participant recalled advice from a colleague saying, 'you need to chill out because they will replace you ... If you died tomorrow ... the team is not going to fall apart and mourn you. They are going to go to work and it continues.'

Impact of barrier and enablers

It is beyond the scope of this pilot study to determine the impact of the barriers and enablers on whether the clinician-manager described themselves as thriving or surviving. However, many of the participants discussed relationships and the importance of relationships during their clinician-to-manager transition. The barriers and enablers that are associated with relationship have been marked (*) on Table 1 to show how many of the identified enablers and barriers were associated with relationships.

Table 1: Enablers and Barriers for the clinician-to-manager transition

Themes	Enablers	Barriers
Preparation	<ul style="list-style-type: none"> ▪ Internal support is available* ▪ Access to suitable training ▪ Self-directed learning (e.g. management books) ▪ Formal qualifications ▪ Career pathways exist 	<ul style="list-style-type: none"> ▪ Inadequately prepared and/or no pre-commencement training ▪ Inadequate training on commencement ▪ Insufficient orientation ▪ Poor handover ▪ Reduced access to training (e.g. travel required)
Assistance-seeking	<ul style="list-style-type: none"> ▪ High self-awareness and good networks* ▪ Access to assistance with new processes and/or systems* ▪ Access to corporate areas for help (e.g. HR, finance)* ▪ Books and/or online resources 	<ul style="list-style-type: none"> ▪ Navigating new processes and systems alone ▪ Lack of confidence in staff ▪ Expecting training and/or waiting to be told what to do ▪ Feeling too busy to seek help
Management, peer and team support	<ul style="list-style-type: none"> ▪ Support, from their line manager, peers and team.* ▪ Mentoring and good role models* ▪ Good relationships and a good support network* ▪ Realistic expectations about support 	<ul style="list-style-type: none"> ▪ Existing support networks no longer appropriate* ▪ Change in line manager soon after commencing* ▪ Ineffective line manager*
Role clarity	<ul style="list-style-type: none"> ▪ Clear expectations from management* ▪ Capable of developing both short and long term solutions ▪ Able to manage the hybrid role* 	<ul style="list-style-type: none"> ▪ Inability to manage the role tension* ▪ Clinical work is prioritised ▪ Lack of dedicated time for managerial activities*
Setting boundaries	<ul style="list-style-type: none"> ▪ Ability to set and maintain boundaries* ▪ Prioritising their needs before the needs of others* 	<ul style="list-style-type: none"> ▪ Inability to set boundaries and unable to maintain them* ▪ Being too accommodating to others*
Work environment	<ul style="list-style-type: none"> ▪ Good systems and processes in place ▪ Inheriting a team that is operating well ▪ Good administrative staff ▪ Able to build strong teams and nurture relationships* 	<ul style="list-style-type: none"> ▪ High turnover and workforce instability ▪ Inherited ineffective systems and processes ▪ Clinical staff have unrealistic expectations of manager* ▪ Ineffective existing systems
Personal characteristics	<ul style="list-style-type: none"> ▪ Ability to access additional resources* ▪ Being solutions focused ▪ Nurture existing personal and professional networks* ▪ Assertive confident manager* 	<ul style="list-style-type: none"> ▪ Perfectionist and/or workaholic ▪ Unable to manage self and workload ▪ Isolated from friends and family* ▪ Unable to say 'no' and/or high in empathy
Self-care	<ul style="list-style-type: none"> ▪ Take regular breaks and leave ▪ Sustainable workload 	<ul style="list-style-type: none"> ▪ Working excessive hours ▪ Unable to prioritise their own needs (e.g. not taking leave)

Are you thriving or surviving?

At the end of each session, each participant was asked if they were thriving or surviving. In most cases, most weeks, they said 'surviving'. Some weeks were worse than others with one participant trying to keep a positive mindset when overwhelmed with work saying,

I've been less than surviving in the last two weeks. I don't know why, okay I do know why, it's that external validation stuff that's come through the last couple of weeks. It's lifted me. I'm feeling like oh okay it's not all doom and gloom but before that I was really struggling and really doubting whether I was cut out to continue to do this job or if I wanted to do this because, I just, it's a lot and ... I hate feeling like I'm not doing a good job. I just hate that feeling.

Another participant felt that she was thriving with her managerial role, but just surviving in other aspects of her role saying, 'I'm probably doing both actually. I definitely am frazzled but I think that I'm managing it well.' The work that this manager had put into building the team, and into finding ways other than *doing it herself* when a clinical gap appeared started to benefit her towards the end of the pilot project. At the last session this clinician manager felt that she was thriving saying,

I think I'm thriving and even when I've had [bad news] ... I still didn't feel it was a disaster in the way that I would have done a couple of months ago. I was thinking "oh god I'm going to have to take your caseload on", [but] because I've started putting those layers underneath [I don't need to take on the caseload]. I've got that waiting list of people who want to come and work for me. I've got some plans. I've got some support from my manager from a funding perspective.

This was consistent with the thoughts of another clinician-manager who said, that when she started to change herself, and change the way she responded to different situations and dealt with issues, she found that the team changed.

What can we learn from the pilot study?

The participants suggested that relationships and personal/professional networks were central to how well they navigated the challenges typical of the key areas that emerged in the study: preparation, assistance-seeking; support, role clarity, setting boundaries, work environment, personal characteristics, and self-care. The emphasis on relationships, communication and networks was consistent with the findings from other research conducted with remote health professionals (Lenthall et al., 2011; Onnis & Dyer, 2017). This is typical of a changing work environment where the focus shifts from transactional management to relational management. According to Di Fabio and Kenny

(2019), relational competencies and emotional regulation are central to improved resilience and individual wellbeing, 'and are increasingly sought by employers for their contribution to organizational effectiveness in a rapidly changing global workplace.' With the work of Seligman's Positive Psychology at its core, Di Fabio and Kenny's study emphasised the role of relational psychological contracts in an environment where transactional psychological contracts are impeded by short-term employment contracts, casualisation, labour hire and flatter organisational structures (Carney & Stanford, 2018; Di Fabio & Kenny, 2019). Within some traditional professions there may be opportunities for professional training guiding traditional career paths; however, this may no longer be at the forefront of organisational priorities as service industry labour is purchased to meet specific demands from a global pool of potential workers, rather than cultivated and nurtured by one organisation.

In the pilot study, the participants all had a high level of self-awareness, and described support seeking activities. Two of the clinician-managers proposed that they found it difficult when they first transitioned due to the lack of support, and being unfamiliar with the processes and systems. They all used policy when they were unsure to ease their anxiety with a given situation; and emphasised the value of existing relationships and professional networks including support from their immediate manager. Psychological Contract Theory (PCT) and Social Exchange Theory (SET) have previously been used to examine remote health workforce sustainability (Onnis, 2016; 2019) and appear to also be relevant theories to explore the clinician-to-manager transition. PCT describes an individual's beliefs about their employment relationship and 'what they think they are entitled to receive because of real or perceived promises' from their employer' (Bartlett, 2001, p.337). While the sample size is too small to draw conclusions, the disappointment and frustration shared by some participants may be partly explained by unfulfilled promises and the clinician-manager's perceived obligations.

Similarly, SET which proposes two types of social exchange, Perceived Organisational Support (POS) and Leader-Member Exchange (LMX) appears relevant to the experiences described by the clinician-managers. POS focuses on the exchange relationship between the employee and the organisation and LMX emphasises 'the quality of the exchange between the employee and the supervisor and is based on the degree of emotional support and exchange of valued resources' (Ko & Hur, 2014, p.177). Some of the clinician-managers described an absence of orientation to their new role, and they all commented on the impact of the level of support they received from their immediate manager, and the organisation more generally, on their clinician-to-manager transition. Regardless of whether they highlighted a supportive manager, or commented on the absence of support from their manager once they commenced the clinician-manager role, they all described their expectations and their perceived level of support.

The impact of high turnover and less secure employment practices, such as short term contracts, secondments and Agency staff was evident in the experiences described by the four participants in this study. The impact of these employment practices was beyond the scope of this pilot study; however, it is anticipated that they will be associated with transactional psychological contracts. Yet, the emphasis on the benefits of relationships and networking by the clinician-managers appear more aligned to relational psychological contracts where reciprocity may be rewarded by loyalty and organisational commitment. Hence, it is proposed that further research will not only contribute to the evidence-base for remote contexts, it will improve the depth of our understanding about clinician-to-manager transitions in contemporary health service organisations.

Feedback on pilot study

In the final interview participants were asked for feedback about the pilot study and how valuable the research experience was for them as they transitioned into clinician-managers.

The general feedback was all positive:

I have definitely found it to be helpful. I get clinical supervision already but this has helped coming really from a management perspective ... I've done management subjects in my Masters degree ... it makes me reflect on things that I already sort of know but then it helps me view it in the real-life.

I think having the time to reflect is really, it's been really valuable for me. It's been particularly valuable because I haven't had that opportunity maybe with my line manager but I think it's actually been really valuable to do from an external perspective.

I really enjoyed it. I'm sad that it's finishing. I found it really helpful. I really liked it. Really looked forward to our sessions and I've liked all the stuff that you sent through so yeah I've definitely really enjoyed the whole process.

The feedback about whether they thought a new clinician-manager would find this type of guidance and support helpful was quite balanced. They thought it would suit some clinician-managers saying, 'what you're doing could easily link in with orientation. I think that what you're doing is awesome and I think it could easily compliment [management programs].' However, there was also a sense that it might not be universally embraced, with one participant saying 'nothing's for everyone. And I think it 'would depend on a level of ability to reflect and be open-minded about different things. You know if you were quite concrete in your thinking maybe that group of people wouldn't find it as helpful.' This is consistent with the literature about the miracle questions, mentoring

and the experiences of others who have tried to implement mentoring programs for remote clinician managers (Cavanagh & Grant, 2010; Onnis et al., 2019).

The feedback about the researcher-mentor was positive:

I think being completely external is good and then being able to speak it through and also you're not bias towards anything ... you're just listening to what I'm saying. So that's definitely been helpful.

I thought oh god I've been really frank and honest in this situation and kind of almost forgetting that you were documenting the conversation ... It's a compliment to you that the conversation is so natural and also it's essential if you're going to get honest data and that people are actually saying what they think. So I think that's really important.

In general, most participants thought that mentoring would be valuable if time were allocated for it. One used her experience with clinical supervision to explain what they thought was needed saying, that 'in terms of the non-clinical work, in supervision it tends to be about how do I do this, this and that' (e.g. how do I manage this difficult clinician); 'rather than how can I think about this issue differently' (e.g. a framework for reflection). Another said, '[I have] always valued supervision but I've always been against it from a mandatory point of view. I think if you force supervision on people it's not necessarily well received.'

When the researcher explained that she had used mentoring because she thought it was a little less confrontational than supervision. The participants agreed, with one participant saying,

I one hundred percent agree. I think there [are] two big things. One is time that we've mentioned, and the other is the relationship ... I think it's that relationship with the person that's really important ... you could match people to other people or you could have external people, there could be a range of people.

Similarly, another participant reflected on the mentoring experience from participating in the pilot project and said,

It works a lot. I mean you're doing this with me now. I've got stuff out of this, this is stuff that I've been learning. The stuff that I've been doing with the women I supervise. I get a lot out of the reflections done with you ... And I'm clearly learning and growing from it. There is a clear benefit to me so it's something I'm keen to continue.

The miracle question

The miracle question supported the solutions-focused strengths-based approach that underpinned this study. This type of question required the participant to emotionally disengage and to step out of the problem. The 'metacognitive distance helps to make visible a solution that cannot be seen when we are 'in the problem' visible to the person seeking the perceived miracle' (Cavanagh & Grant 2010, p.61). For this study, the aim was for the clinician-managers to be able to visualise how their team could operate and then to plan and implement small changes to move closer to the miracle scenario. At the same time, it helped them to differentiate between what they had influence over, and what was a feature of their environment.

I think the miracle question is good for that. It's that forward, this is where I want to be. That's how I looked at it. This is what I want so what are the steps I need to take before I can get to that stage. I think that that's a good way to frame what you want and I think the other thing that's useful is that if you picture that end goal it gives you a bit of motivation.

The language of the miracle question can be difficult for some people who see the terminology as silly and 'experience talk of miracles as polyanna-ish' (Cavanagh & Grant, 2010, p.61). The concept of miracles and their ability to reframe issues may need some refinement as those who deemed themselves to be more practical people mentioned that they found it a bit abstract; however, they did still find benefit from the approach, with one participant saying:

The miracle question 'was a nice way to shape your thinking about stuff ... when you first asked it, I thought "Oh god, this is a bit airy fairy" ... I'm quite a practical person. The word miracle, I remember the first time thinking oh a bloody miracle but actually I do like the question. I think it does help shape your thinking ... there's a small part of it which brings out some cynicism because you're like oh what do you mean there's no bloody miracles ... but then actually when you think about it, actually even moving forward to where you are and getting through on a daily basis sometimes that just feels like a miracle. But in some ways the word miracle is good ... I think the question does make you think well what's an achievable goal and what's just a dream. So the miracle is that, even though I laughed a little bit at the phrase of it ... it does focus your mind on what's realistic and what's just complete fantasy.

Improving the research process

The participants were asked if there is anything that could improve the research process. All of the participants thought that this research process would be beneficial to a new clinician-manager. Most significantly, the two participants who completed the entire research process (initial interview, reflective discussions and final interview) found the

research process to be beneficial, with one participant saying, 'this has never felt like a burden even though I'm super busy' and the other participant saying:

I think that what you've done is guided it in a direction naturally from what's come up ... So, it's already quite a flexible, individual approach. So it's not necessarily that I felt you've applied a firm framework that wasn't applicable to what I was thinking about, maybe you have, maybe you haven't but because of its individual nature I think that it could benefit each person, they just bring up the things they're wanting to work on or their concerns of the day. I don't have any particular recommendations about how you'd adapt it. I think that, I think that it'd be really useful.

In summary, it appears that the pilot study has identified areas where some improvements can be made. For example, the invitation and recruitment process needs to be refined to attract clinician-managers suited to this type of process. The flexible and organic research process identified barriers and enablers that may not have emerged in a traditional post-experience interview. The participants did not find the interviews and discussions to be a burden and found the time involved with the research study to be a good use of their time. One participant completed the two interviews and due to her reflective style of working provided a lot of insight in the final interview about her experience without the regular reflective interview component. One participant is no longer working as a clinician-manager and chose to only participate in interview one. The paper presented at the ANZAM conference contained data from the first interviews; therefore she was included as a participant despite not participating in the reflective discussion or the final interview.

Co-produced narratives

The six-month duration of the study was not long enough to trial the process for the co-produced narratives. As a result, a participant from a remote area outside of FNQ was invited to participate in the study with a view to co-produce and publish a paper about her clinician-to-manager transition experience. The data has been collected, analysed and a paper has been drafted. Together the participant and the researcher plan to publish this narrative of a successful clinician-to-manager transition in a remote area. The lesson from this pilot study is that there needs to be a reasonable passing of time since the transition for the clinician-manager to have sufficient insight into all aspects of their experience and that it takes a lot of time to co-produce publishable narratives.

Limitations

This pilot study is limited by the small sample size. The study did not attract any Indigenous participants or participants from non-English speaking backgrounds which is noted, along with the lack of gender-balance as a limitation in this study. For these reasons, the pilot study is being used to refine the exploratory research methods and to

further our understanding of the barriers and enablers for clinician-managers based in remote areas.

Conclusion

This pilot study built on existing research which had revealed the need to support clinician managers in remote contexts to develop good management practices in order to improve workforce sustainability (Onnis 2015; 2016; Onnis et al., 2019). The pilot study sought to understand more about the barriers and enablers for a successful clinician-to-manager transition to improve our understanding about why some clinicians thrive as clinician managers in remote areas, while others do not. The findings from this study suggests that thriving and surviving are not only subjective they are fluid, that is, a clinician-manager may change their opinion about whether they are surviving or thriving on any given day. However, the clinician-managers who appeared to be coping better for the majority of the study had a healthy approach to the fluctuations and brought the balance back towards what they perceived as thriving. For health service managers and developers of management development programs, it appears that this type of mentoring/coaching approach could compliment structured programs; however participation should be voluntary as participants made it clear that it would not suit everyone.

The findings suggested that the flexible, organic personalised approach used in this research study meets the needs of busy clinician-managers with varying needs for support. Furthermore, the fact that the research was conducted by an external person, someone who was effectively a stranger to the participants, appears to not have any negative impact on the study. This suggests that where researchers can nurture and build professional relationships with participants the research design used in this pilot study may be feasible for other remote working populations. Hence, given the increase in professionals working in remote and isolated locations, the research suggests that if both parties are able to build a relationship using technology (telephones, skype, and emails) as well as human contact, this type of support could be offered to more remote managers. Given the increase in casual workers, gig workers and people working-from-home, this approach could be a cost-effective alternative to high cost management programs that require travel, accommodation and professional venues, as well as the associated lost time and increased burden on busy managers.

The findings from the pilot study suggest that the barriers and enablers identified by the remote clinician-managers may be relevant to urban clinician-managers. Therefore, it is possible that the findings from further research about the clinician-to-manager transition for geographically remote-based clinician-managers could inform a broader investigation about how to prepare and support hybrid managers working remotely, or with remote workers, in urban areas.

Recommendations

Recommendation 1: It is recommended that the lessons from this pilot be used to conduct the study with a larger sample across a wider geographical area (e.g. nationally) to see whether there are any additional barriers and enablers for the clinician-to-manager transition. Also, a larger sample will help to identify any further areas for improvement in the research design.

Recommendation 2: If this pilot study was to be scaled up for a larger study it is important that it is adequately funded and resourced. It is a large undertaking to nurture the type of relationship needed to provide the level of support that some clinician-managers may need during the transition.

Recommendation 3: The mentoring/coaching relationship is based on trust and absolute confidentiality. An external mentor/coach is recommended as it gives the clinician-manager the opportunity to be vulnerable, open and honest without fearing repercussions from within the organisation.

Recommendation 4: It is recommended that a mentor and/or peer support be included in the research team to guide and support the researcher conducting the interviews.

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