

Breaking Down Professional Boundaries: How can Doctors and Managers Work Together to Better Manage Health Care Organisations?

BREAKING DOWN PROFESSIONAL BOUNDARIES: HOW CAN DOCTORS AND MANAGERS WORK TOGETHER TO BETTER MANAGE HEALTH CARE ORGANISATIONS?

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ABSTRACT

This paper explores the relationship between doctor managers and senior health service administrators (CEOs or General Managers) within the context of Australian health reform. Government funding for health services has become increasingly driven by government defined measurable performance targets and resources. These policy changes have implications for hospitals to be managed more cost effectively and efficiently. Hence, one of the challenges of health reform, for those managing hospitals, is a need to have a unified position in their collective ownership of managing the organisation. However, differences in the professional cultures, backgrounds, and training of health service administrators and doctor managers influence how each actor thinks about their roles as managers within the hospital. This paper reports on qualitative data used to explore the role of doctor managers in Australia. One area identified by the research participants was that high levels of hospital CEO turnover contributes to lack of engagement between doctor managers and senior health service administrators, influencing their ability to meet the continual challenges of health reform. This paper highlights the need for future research to expand understanding of doctor manager and health service administrator engagement as they work together toward meeting the demands of health reform.

INTRODUCTION

Since the late 1980s, one of the major changes to Australian hospitals has been the introduction of New Public Management (Degeling, Maxwell, Kennedy & Coyle, 2003; Fitzgerald & Ferlie, 2000; Mo, 2008; Vera & Hucke, 2009). New Public Management is a neoliberal concept that has brought a managerial orientation to managing hospitals. As such, hospitals are driven by the need for cost reduction and organisational efficiency, and this perspective is known as 'the business of health' (Braithwaite, 2004).

At the same time as the introduction of New Public Management into Australian hospitals, the landscape of health service delivery experienced significant

changes. There have been increasing costs that relate to changes in technology, and the development of pharmaceuticals, an ageing population, and increasing incidence of morbid diseases in the community (Braithwaite, 2004; Duckett, 2007). These changes have placed financial strains on hospitals and their budgets.

Furthermore, such changes in healthcare have also been met with, what has come to be termed, 'a decreasing health care dollar'. Given that hospitals account for almost two-fifths of total health spending in Australia, there is a legitimate and ongoing health policy debate about hospital costs and efficiency (Duckett & Willcox, 2011). As a result of this ongoing debate, the allocation of funds to hospitals by government has progressively demanded more accountability from hospitals to government. The consequence of the government's ever-increasing requirement of accountability for public monies in healthcare funding is the obligation for each hospital to meet performance targets based on quality, safety, and efficiency (NSW Health, 2010). As such, hospitals are now required to compete with other hospitals for their yearly funding under a Commonwealth and State Government initiative known as Activity Based Funding (ABF) (Government 2008). The Commonwealth and State governments demand a more transparent and efficient use of tax payers' money for funding hospitals through the ABF model. The ABF model is based on classifying, costing, and measuring each level of all patient related services across different care types and settings in every Australian hospital (Government 2008). As a result of ABF hospitals are now more accountable to government for their budgets than ever before.

The increasing internal and external pressures on hospitals highlights an important challenge for those who manage these organisations, the individual managers within the hospital need to have a unified position in their collective ownership of managing the organisation. A cohesive management group is essential for improved patient safety, quality of care, and organisational performance (Kirkpatrick, Shelly, Dent & Neogy, 2008).

The purpose of this paper is to identify an area of tension that influences the relationship between the hospital's senior health service administrators and doctor managers. A doctor manager has a dual doctor and organisational role within the hospital. They are responsible for managing their department, including resource expenditure, budgets and staffing, as well as the individualised cure and care of patients (Braithwaite, 2004; Iedema, Degeling, Braithwaite & White, 2003).

The results of preliminary research have identified that high levels of CEO turnover in hospitals contributes to lack of engagement between senior managers and doctor managers. A high level of CEO turnover was reported to

influence the ability of doctor managers to engage with senior administrators to meet the continual challenges of health reform. Understanding what influences the CEO and doctor manager relationship, and their ability to engage with health reform is important from a human resource management perspective because attitudes to managers impact employee engagement at work (Wright, 2012).

This paper uses data from a qualitative research exploring the role of doctor managers in Australian hospitals. The preliminary research results used in this paper raise the question about what influences the senior health service administrators and doctor manager relationship when engaging with health care reform. Doctor engagement has been identified in the literature as an important aspect of implementing health reform (Clark, 2012; Guthrie, 2005). However, there is little in the literature about how engagement is influenced between doctor managers and senior health service administrators in Australian hospitals.

The remainder of this paper is organised as follows. The first section of the paper reviews the literature on doctor managers, health service administrators, and doctor engagement. The second section of the paper outlines the methodology used to undertake the research. In the third section of the paper, the responses of doctor managers and senior health service administrator about engagement are presented and analysed in relation to current theory. The conclusion discusses the implications of the findings for doctor managers and senior health service administrator engagement in relation to health reform. Finally, suggestions for a number of areas for further research are made.

LITERATURE REVIEW

The doctor manager's role in Australian hospitals

A doctor manager is a doctor working in both a doctor role and managerial role within the health care organisation (Braithwaite, 2004; Fitzgerald & Dufour, 1998; Fitzgerald & Ferlie, 2000; Fulop & Day, 2010). Doctors are seen as most crucial in achieving health reforms at strategic and operational levels. They hold considerable power over a shrinking resource base, and are able to argue from an authoritative and, at times, evidence based position about how resources should be allocated (Swanwick & McKimm, 2011). Thus, increasing doctor input into the development and prioritisation of health service strategies can be seen as one of the most important advantages of the doctor manager role (Dedman, Nowak & Klass, 2011).

The doctor manager role is beneficial because doctors are able to bring unique clinical insights into healthcare management that non-doctor managers are unable to do (Thorne, 2002). For example, doctors have in-depth knowledge of how hospitals work. Their extended hospital training and experience gives them an undeniable breadth of knowledge in the day-to-day workings of the organisation. Furthermore, they understand the politics of healthcare (for

example, the influence from their networked collegial affiliations outside the organisation, such as the AMA or specialist colleges) to the internal politics within the organisation; giving them the external and internal understanding of how healthcare is organised (Long, Forsyth, Iedema, Carroll, 2006). Additionally, a doctor's knowledge on how clinical medicine is practiced provides insight into the clinical implications of management decisions on health service delivery.

Finally, and what might be considered most important, is their understanding of how their clinical colleagues think. For instance, differences in professional cultures, backgrounds, and training of managers and doctors influences how each actor thinks about their roles in the healthcare organisation. Such differences have been described as 'two tribes' which are often in conflict due to their differing perceptions of the health care environment (Degeling & Carr, 2004; Degeling et al., 2003; Kirkpatrick, Dent & Jespersen, 2011). Therefore, the role of the doctor manager is to have an understanding of both the clinical view and the managerial view of healthcare reform.

The health service administrator's role in Australian hospitals

Health service administration is seen in healthcare organisations as a distinct profession. The professionalisation of managerial work has been supported by an increasing number of business schools and training programmes for managers globally (Mintzberg, 2004). Such professionalisation is demonstrated by a professional body that provides a range of development programs for members that are specific for health service administrators; such as specific higher education degrees that focus on managing within the complexities of health care services and a common management language that is shared by health service administrators.

The health service administrator of a hospital has control over the organisation (Glouberman & Mintzberg, 2001). They are concerned about the patient experience within the healthcare organisation (Edwards & Marshall, 2003). Moreover, they have been entrusted with formal managerial authority through administrative hierarchies to control the overall resources of the organisation (such as budgets, beds, and jobs).

Health service administrators are part of the organisational hierarchy and their incentives for their work practice are aligned to organisational goals. They rely on the formal organisational rules and processes to make transparent decision making within the organisation (Degeling, Kennedy & Hill, 2001). Additionally, health service administrators draw on qualitative, experiential, and anecdotal evidence in making management decisions (Kirkpatrick et al., 2008). Therefore, health service administrators use specific control measures as a way of managing the organisation.

Furthermore, health service administrators use management language, based on budgets, targets, and measurements. Therefore, they hold strongly systemised conceptions of clinical work and financial realism and transparent accountability (Degeling et al., 2003). In their role of addressing organisational resources issues, health service administrators use a rationalised output-oriented approach to health service delivery.

Health service administrators also exercise their formal authority over organisational members (such as nurses and cleaners) who have least claim to professional status (Glouberman & Mintzberg 2001). However, clinicians, through their professional associations, have control over how they practice medicine. In other words, health service administrators have authority over all employees other than medical clinicians. Medical clinicians have a strong allegiance to the medical profession and this impedes the health service administrator's authority to influence the individualistic medical working practices (Horsburgh, Perkins, Coyle & Degeling, 2006). Hence, the limited authority of health service administrators over clinicians leaves them as outsiders with regard to the clinical operations of the healthcare organisation. However, although health service administrators may not be able to regulate clinical work, they can often limit and direct its application through control over resources.

One of the aims of the National Health and Hospitals Network Agreement is to have more involvement of medical clinicians in operational and strategic decision making (NSW Health, 2010). In order to successfully implement health policy reform it is important to understand the impact that the reform has on those who enact the new system (Spurgeon, Mazelan & Barwell, 2011). This view further supports the need for engaging medical clinicians who work in hospitals.

Engaging doctors in response to health reform

As discussed above, the drive by government to improve the delivery and effectiveness of health care is dependent on the support and active engagement of doctors; not only in their clinical activities but also in their management and leadership roles (Clark, Spurgeon & Hamilton, 2008). Engagement has the potential to motivate individuals to be more involved in an organisation's processes (Spurgeon, Clark & Ham, 2011). Thus, engaged employees have a sense of satisfaction that has a positive effect on their work performance that leads to improved organisational performance.

Engaging doctors in organisational change processes is vital for several reasons. First, doctors have a stronger allegiance to their profession than to the organisation in which they work (Fulop & Day, 2010; Kirkpatrick et al., 2008; Kitchener, 2000). As a result of their professional allegiances and obligations, doctor engagement needs to come from within their profession, not from

outside their professions hierarchy. For instance, trust and credibility comes from within the medical profession, not from those outside the clinician's collegial boundaries, such as managers.

Second, doctors have the responsibility for the delivery of services and the quality and safety of patient care (AMA, 2010). Therefore, doctors need to understand and engage with what impact hospital performance targets will have on the delivery of their clinical service provision. For instance, doctors in their clinical practice are accountable for the safety of their patients. Changes to clinical practice can directly affect their work practices and therefore it is essential they understand why changes are being made.

Third, doctors resent the continual health reform that they perceive has brought new structures of governance and cost controls to service delivery that is not synchronised with their clinical practice (Spurgeon, Clark & Ham, 2011). For example, doctors believe that managers are more focussed on making decision that meet prescribed performance targets than the clinical priorities of health care (Crilly & Le Grand, 2004). Therefore, as for the above reasons, engaging doctors is essential in health reform because when doctors perceive they have little understanding of the healthcare change process, they are less likely to support health reform agendas (Council of Australian Governments, 2011; Degeling & Carr, 2004; Spurgeon, Mazelan & Barwell, 2011).

Furthermore, the literature suggests that engaged employees perceive themselves as part of the whole organisation in which they work (Spurgeon, Clark & Ham, 2011). Doctor engagement in healthcare organisations has resulted in better performing hospitals (Guthrie, 2005) and improves the financial bottom line of hospitals (Paller, 2005). Therefore, the importance of doctor engagement is a significant issue for healthcare organisations because when doctors are engaged with health service reform, effective change policies are more likely to be successfully implemented; bringing benefits to the overall performance of the organisation.

METHODOLOGY

The research adopted a qualitative methodology to explore how and why individuals work in a doctor manager role. A total of 23 interviews were conducted, five with senior health service administrators (CEOs or General Managers) and 18 with doctor managers in four NSW public hospitals.

Research methods used to collect the data were semi-structured interviews, observation, and field notes. Interviews were conducted over the period between October 1, 2009 and March 30, 2010, in several large hospitals within the Area Health Service in Sydney, Australia. The interview questions were broadly framed around the research participants' experiences and perceptions of

the doctor manager role. The interviews were conversational and new questions were based upon themes revealed by previously completed interviews. This allowed a systematic approach to collecting the data. The interviews were recorded and transcribed verbatim. QSR N-Vivo® software was used to aid detailed coding and analysis of the collected research material; facilitating the interpretation process. Member checks – in which the data and interpretations were provided to participants for correction, verification, and challenge – were used to increase the credibility of the research. Through the analytic phase of the project, a number of core themes emerged from the data that will be discussed in the findings section. Through a reflective and iterative process, theme content was interrogated to explore relationships between and within the themes.

Qualitative research provides weak levels of generalisation and reliability as it is subject to the reality that observed patterns are time bound and context bound, and may not be sustained beyond the period of the study. Issues of generalisability can be addressed by arguing that qualitative research is concerned with analytical generalisations, used to develop theories and not statistical generalisation to a larger population (Hayes, 2007).

FINDINGS

Clark (2012) suggests that high performing health systems and organisations require high quality engagement with doctor managers (DMs), as well as the stable leadership of the organisation. For example, it is the role of the leaders to create a culture that encourages and fosters engagement at all levels of the organisation (Armit & Roberts, 2009). Therefore, engaging DMs at a strategic level and a personal level should be key priorities for executive administrators in healthcare organisations (Guthrie 2005).

The DMs' responses during the research suggest that they experienced obstacles in building the relationships needed for their engagement with senior managers. During the interviews, it was observed the DMs had a sense of antagonism towards the senior managers of their organisation. The manner in which the DMs spoke about the managers led to a sense that they felt little collegiality towards them. It was noted that a couple of the DMs actually sat upright and became stiff in their demeanour when talking about managers. The way the DMs responded did not give a sense of any engagement between the DMs and the managers. The following section will illustrate the interviewees' views on the DM and manager relationships.

One DM said:

There is a lot of goodwill that goes in running a hospital by clinicians, and there has been a perception by management that there is no such thing as goodwill and it is not important. (DM 3)

DM 3's response suggests he gives far more to the organisation than what he perceives is recognised by senior management. In a sense, he is alluding to his perception that the work that clinicians do goes above their clinical load and is undervalued by managers. His response is supported by the literature that suggests when clinicians talk about engagement, they are referring to what they already give that is not appreciated, valued, or supported by management (Clark, 2012; Erlandson & Ludeman, 2003). Thus, when DMs perceive their benevolence to the organisation is undervalued, they are likely to feel some resentment; which creates a climate where they are less likely to be open to engagement opportunities with senior managers.

Another DM perceived the level of senior management turnover was a barrier to developing relationships with senior managers:

They (General Managers) don't stay. They come and go and it is not as though they stay for 10 years to develop a relationship. (DM 8)

DM 8's response suggests he perceives the high level of turnover of general managers does not facilitate a DM and manager relationship. The literature suggests that clinical engagement occurs, at a management level, when senior management get to know the DMs they work with (Clark et al., 2008). Therefore, when organisations experience such high turnover of executive managers there may be less opportunities for DMs to build a cohesive and co-operative ongoing relationship at the senior organisational level. Considered from a differentiation perspective, the lack of cooperation may mean that the DMs and the managers have independent and/or conflicting relationships.

And another DM stated high turnover of managers was an issue:

What has happened is that the (position withheld) manager left, another one. I don't think I am lying when I say I have had 10 in 11 years. (DM 12)

DM 12's response suggests two issues. First, he shows his frustration with having to deal with so many different managers. One of the consequences of executive turnover in health care organisations is the destabilising effect on both the organisation and the staff (Havens, Thompson & Jones, 2008). As a result of ongoing changes in senior executive positions, there can be disturbances to the

strategic planning process of the organisation (Khaliq, Thompson & Walston, 2006; Wilson, Harriet & Joseph, 2000) and loss of human capital (such as loss of organisational knowledge) (Rondeau, Williams & Wagar, 2009). For example, a lack of understanding of the organisation's history and culture may impact on the general manager's ability to apply his or her organisational knowledge in setting new directions for the organisation. Considered from a fragmentation perspective, executive management turnover can be seen to suggest that disruptions in the leadership role may interrupt organisational planning processes.

The second issue that DM 12 alluded to was the length of time that he has occupied his doctor manager role. This suggests that there are differences between the executive managers' and DMS' stability in occupying their roles.

One manager recognised the low turnover of DMS:

They (some DMS) have been in their departments for 20 years. No turnover there. (Manager 4).

Manager 4's response further supports the view that the turnover of the DM's role is low. As a result of their low turnover, some DMS may have more extensive organisational and service knowledge than that of a new manager; which may enhance their contribution to delivery and effectiveness of healthcare delivery. In effect, the experiences of DMS regarding historical organisational change initiatives may lead them feeling resentful of further changes that will impact on their clinical and managerial roles. Another outcome of low turnover in DMS, may be that they resist organisational change initiatives because they are comfortable with the way their department runs and how their clinical work is enacted.

However, the recognition that DMS have low turnover in their roles suggests a difference in clinical and management cultures in relation to role stability. For instance, Manager 4's response suggests there is more stability in clinical roles within the workplace as opposed to the perceived high turnover of executive management positions. Where such contrasts exist, this suggests that there may be greater support for engaging clinicians in the broader organisation's objectives because of their extensive experience and knowledge of the healthcare organisation (Clark, 2012). For example, DMS have the organisational knowledge that can provide historical background for executive managers to draw on when making strategic decisions. Conversely, DMS may feel frustrated when senior managers promote their own agenda and have little interest in the history of the organisation.

Furthermore, these differences in turnover between the executive managers and DMs may also account for some of the tensions they experienced. DMs may experience resentment when they are required to be accountable to what they perceive as a revolving door type of leadership (Adams, Heans, Sturgis & Clark, 2006; Khaliq et al., 2006). DMs may perceive management executives as having little understanding of the history of the organisation and, at the same time, have the authority to make significant organisational changes that impact on clinical practice. Such resentment may impact on how DMs and managers engage at a strategic and operational level.

One DM saw the manager's lack of organisational understanding as frustrating:

There has been poor management in this place (hospital). There is a lack of understanding of how the system works. (DM 8)

DM 8's response, in the context of high management executive turnover and low clinical turnover, suggests that DMs perceive they have more understanding of the organisation than some of the managers. His comment suggests that it is his belief that, as a result of high executive turnover, executive managers have less understanding of how the organisation works which in turn affects their ability to manage the organisation.

Another DM recognised that the differing management styles in CEOs also present challenges for DMs:

Since 2001, when I started here, we have had 8 CEOs in that time. Each CEO, and some were acting in that position, changes how things worked. (DM 7)

DM 7's response illustrates the need for DMs to adapt to the different management styles of the changing executives. His response suggests that whether the CEO is permanent or acting in the position, their different ways of working can have a significant impact on those who report to them. Duffield et al (2011) suggests that high rates of senior executive turnover leads to uncertainty in the ranks of other staff members (Duffield, Roche, Blay, Thorns & Stasa, 2011). Therefore, a high level of CEO turnover brings challenges in building new relationships which may create uncertainty in how DMs manage and set the direction of their service.

IMPLICATIONS

This research has shown that the high turnover of senior health service administrators has potential implications for the administrator and DM relationship. The increasing need to create collaborative and effective relationships between DMs and administrators to overcome the divide between

the medical profession's norms and managerial imperatives is supported in the literature (Armit & Roberts, 2009; Clark, 2012; Ham, 2003) and in government structural initiatives to healthcare organisations (Council of Australian Governments, 2011; Steering Committee for the Review of Government Service Provision, 2012). However, implementing structural changes to healthcare organisations, such as the doctor manager role, has not necessarily decreased the divide. This research has shown that it is the relationship between the incumbents of each of the roles that is necessary for engagement, not the roles per se.

The literature on clinical engagement suggests that there is potential for DMs and senior health service administrators to work together to create a culture that encourages clinicians to become more actively involved in transformation of their health services. However, this research has shown that high executive turnover may impede the relationship between DMs and health service administrators, which is essential for clinical engagement at the executive level. As discussed earlier, there are significant implications for health service administrators and DMs with the introduction of ABF within the newly structured Local Health Districts. DMs and health service administrators need to work more closely together to respond to performance targets so as to ensure their organisation's funding is maintained or increased. However, before clinician engagement occurs, DMs need to understand and promote health reform initiatives. As Guthrie (2005) suggests, such engagement occurs at senior management level, between DMs and senior management.

FUTURE RESEARCH

This research has identified areas of potential barriers to engagement between DMs and senior health service administrators. However, more specific research on the relationship between doctor managers and senior health service administrator is an area for future research. Further research into what influences their engagement as they work together toward meeting the demands of health reform would be beneficial. The management implications of ABF, as discussed earlier, has the potential for government to withhold funding to hospitals that do not meet set performance targets, means that managers need to work closely together at a strategic level to address the increasing government demands. This means that the relationship between doctor managers and senior administrator becomes pivotal. Therefore, it would be useful to conduct further research around what facilitates or impedes the relationship between doctor managers and senior health services administrators.

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