PROFESSIONAL IDENTITY: ENABLER OR BARRIER TO CLINICAL ENGAGEMENT?

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ABSTRACT

The purpose of this paper is to obtain a better understanding of how leadership is enacted by hybrid doctor-managers (DMs) as well as what engagement strategies hybrid doctor-managers use with their clinical colleagues that may influence organisational objectives being met.

This paper provides empirical insights into how hybrid doctor-managers, in their leadership role, engage with their clinical colleagues. The findings suggest that in only a few cases, doctor-managers combine both their organisational and clinical leadership role. As clinical experts, they naturally take on a clinical leadership role, but many fall short in also taking on a managerial leadership role, working towards organisational objectives, such as meeting the key performance indicators, promoting an efficient use of resources and leading organisational change initiatives. We also found that doctor-managers do not have clear role descriptions and that doctors lack managerial qualifications.

The results of this study support the proposal that conformity in how the doctor-manager role is implemented would be of benefit to the health care organisation. The creation of the hybrid doctor-manager role is the main strategy for health care organisations to engage clinicians with health reform initiatives through organisational goals and objectives. To accomplish such engagement, a defined job description with clear role responsibilities and accountabilities is needed. Through understanding what influences the engagement strategies of doctor-managers, it is suggested that closer attention to recruitment and training is required and wanted. This study supports the recommendation that management and leadership training are an essential requirement when recruiting appointees to a hybrid doctor-manager role.

INTRODUCTION

Traditionally, clinicians (doctors) hold a significant amount of power and influence within a health care organisation (Abbott, 1988) to achieve the organisation's objectives around the delivery of quality care. As a result of the clinician's autonomy and authority, they have the power to decide if and when organisational directives that affect clinical practice will be implemented or not (Nugus, Greenfield, Travaglia, Westbrook, & Braithwaite, 2010). However, new public management pressures to provide efficient services are not necessarily providing the platform that clinicians want when delivering their care(Spurgeon, Clark, & Ham, 2011). The perception is that efficiency and best practice are at odds with one another and this is effectively dividing health care workers into two camps: those with managerial functions and those with clinical functions (Glouberman & Minzberg 2001; Fitzgerald & Ferlie 2000). To counter the great divide, the role of the DM was created (Fitzgerald & Ferlie, 2000; Braithwaite & Westbrook, 2005). A DM is a doctor working in both a clinical role and managerial role within the health care organisation (Braithwaite, 2004; Fitzgerald & Dufour, 1998; Fitzgerald & Ferlie, 2000; Fulop & Day, 2010). However, the role of the DM is not well developed, nor well understood.

One pressing organisational objective is to enable the health care funding model to be more efficient and effective. This requires clinicians to be aware of how their clinical practice is influencing, and how it is influenced by, organisational key performance indicators (KPIs). The introduction of activity based funding (ABF) by the Australian government to all hospitals in Australia requires them to perform (Australian Government, 2009). Hospitals face increasing pressure for efficiency, service quality and patient safety (Sorensen, Paull, Magann, & Davis, 2013). The demand for organisational efficiency and cost reduction means that clinicians are required to measure and account for their clinical practice decisions. Therefore, there is a need for them to understand that their clinical practice is closely related to the organisational objectives, and hence, there is a need for DMs to engage their colleagues with management decisions and align clinical and organisational objectives.

It is suggested that when doctors are given a management function, they are more likely to engage with the objectives of the organisation and are more likely to implement changes to clinical practice (Dedman et al; Fitzgerald & Ferlie, 2000; Swanwick & McKimm, 2011). However, engaging clinicians with health reform policy is a difficult task.

The introduction of the role of the DM, whilst challenging, is seen as pivotal to the introduction of health care reform. Those who occupy the DM role are often seen by their colleagues as clinical leaders, or experts in their domain (Thorne, 2002). Their clinical leadership role is embedded in the trust between clinicians (Ham, 2012). It is this trust that the senior managers in hospitals aim to draw on when recruiting a DM. When clinicians trust and respect a DM there may be an increased likelihood that clinicians will accept the management objectives and decisions that the DM is charged with implementing.

However, the DM role is paradoxical (Kippist, 2012; Kippist & Fitzgerald, 2010). The aim of the role is to engage clinicians with organisational objectives. Yet, often those who occupy the DM role perceive organisational objectives through a clinical viewpoint only, rather than through a holistic organisational viewpoint. The influence of such a clinical perspective maintains medical dominance within the organisation and often results in clinicians not really engaging with the organisation's objectives.

Paradoxes emerge from within the organisation and the individual, resulting in inconsistencies in how DMs execute their managerial processes and practices (Kippist, 2012). Where the DM role has been poorly structured, DMs draw on their clinical frame of reference of how their management role is organised and enacted (Braithwaite & Westbrook, 2005). This occurs, for example, when they make management decisions from an individualistic clinical perspective, rather than from a manager's collaborative perspective.

From the individual DM's perspective, their management behaviour is influenced by their clinical values and beliefs about 'clinicians' and their dominant role within the hospital. For example, the DM's clinical frame of reference influences their professional identity and their behaviour when they choose an 'either/or' identity (doctor/or manager) rather than 'either/and' identity (doctor/and manager) (Kippist 2012).

This paper will first assist in gaining further insights into the role of the DM within Australian hospitals. It will identify specific engagement strategies used by DMs and it will suggest implications for impeding such engagement strategies. Finally, it will make recommendations for practice.

BACKGROUND

The Australian health care context

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. This perspective is known as 'the business of health' (Braithwaite, 2004).

Such changes in health care have also been met with what has come to be termed as 'a decreasing health care dollar' (Degeling et al., 2003). 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. The consequence of the government's ever-increasing requirement of accountability for public monies in health care 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 against one another for their yearly funding under a commonwealth and state government initiative known as activity based funding (ABF) (Australian Government, 2009). The commonwealth and state governments demand a more transparent and efficient use of tax payers monies 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 (Australian Government, 2009). As a result of ABF, hospitals are now more accountable to government for their budgets than ever before.

The increasing pressures on hospitals highlight an important challenge for those who manage these organisations. First, there is a need for the individuals working in management positions to possess sound knowledge of business principles. Second, the managers of the organisation need to have a united position in their collective management of the organisation. Therefore, DMs need to understand that, in addition to having clinical responsibilities, they are part of the management team, responsible for running an efficient high quality service.

Given the ongoing demands in health care, the DM's role was introduced into New South Wales in 2001. The dual role was implemented to engage clinicians with management objectives so that they could better contribute to the significant changes to health service delivery (New South Wales Government 2001). Engaging clinicians with the organisation's objectives is pivotal, as clinicians play a major role in the health reform agenda as they are the most

powerful group who use more resources than others in the organisation (Degeling & Carr, 2004; Fulop & Day, 2010).

Therefore, it is the increased emphasis on clinical performance management and resource constraint that drives the need for those occupying a DM role to use leadership strategies that engage their clinical colleagues with health reform initiatives.

The doctor manager's role in Australian hospitals

A DM is a doctor working in both a clinical role and managerial role within the health care organisation (Braithwaite, 2004; Fitzgerald & Dufour, 1998; Fitzgerald & Ferlie, 2000; Fulop & Day, 2010). Clinicians are seen as most crucial in achieving health reforms at strategic and operational levels. Clinicians 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 clinical input into the development and prioritisation of health service strategies can be seen as one of the most important advantages of the DM role (Dedman, Nowak, & Klass, 2011).

Additionally, the clinician's knowledge of how medicine is practised 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 clinicians influences how each actor thinks about their roles in the health care organisation. Such differences have been described as 'two tribes' that 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 DM is to bring the business of health and the practice of health to health care reform by making significant change in the clinical domain.

Controlling clinical practice

Although health care policy makers make adjustments to health care systems through reform agendas, it is the acceptance and implementation of these policies that occurs at the front line of health service delivery. Yet, it is the clinicians who have the power to make policy changes happen or not (Nugus et al., 2010). The influence clinicians have on the implementation of health care policy reinforces the need for those who occupy the DM role to engage clinicians as a way of easing the implementation of policies to clinical work practices.

Thus, the role of the DM can be understood via two differing perspectives. From management's perspective, the role of the DM can ease the tensions between clinicians and management, as they can bridge the power gap between clinical and organisational decision-making processes (Fitzgerald & Ferlie, 2000; Ham, 2008; Iedema, Degeling, Braithwaite, & White, 2003; Thorne, 2002). From the clinician's perspective, the dual role can act to defend clinical authority and autonomy from imposing management agendas.

Health care organisations can be explained and understood as professional bureaucracies (Mintzberg, 1979; Spurgeon, Clark, et al., 2011). A defining characteristic of a professional bureaucracy is control. For example, clinicians control and dominate clinical service delivery through their expert knowledge and skills. Hence, directives from those nominally in control of the health care organisations, such as non-clinical managers will often have very little impact (Ham, 2008). For this reason, control over clinical colleagues comes from within the medical profession. Hence, implementing health policy change in a professional bureaucracy, such as a hospital, depends on engaging clinicians through a more distributed leadership approach in which the professionals themselves play a key role (Stanton & Lemer, 2011) and not imposed externally from management.

Leadership

Clinicians tend to come into the dual role because they are recognised as leaders by their colleagues for their clinical expertise and skill (Howieson & Thiagarajah, 2011). For example, clinical leaders are perceived as early adopters of new technologies and practices in health care (Dywer, Becker, Hawkins, Mckenzie, & Wells, 2012) and act as leaders by implementing changes in clinical practice.

The role of the DM is to lead and implement organisational policies that shape and influence the future patterns of health care (Fitzgerald & Ferlie, 2000; Fulop & Day, 2010; Ham, 2008; Vera & Hucke, 2009). Leadership can be described as an individual's ability to set direction, influence others and manage change (Swanwick & McKimm, 2011). The success of leading clinical colleagues is through the DM's perceived institutionalised professional knowledge, giving them authority and legitimacy that provides leadership to colleagues (Evetts, 2011; Mo, 2008). Thus, raising clinical standards and improving performance in health care organisations depends on the respect, through a shared common background, that DMs have with clinical colleagues (Clark, Spurgeon, & Hamilton, 2008; Fitzgerald & Ferlie, 2000; Ham, 2008).

Thus, the leadership role of the DM can be understood in terms of mutual interdependency (Spurgeon, Clark, et al., 2011). Those who occupy a dual role exercise influence through shared professional values and interests with their peers. As a result, the DM's role is different to other management roles in the health care organisation. For instance, those who occupy the dual role represent clinical standing and are therefore perceived by clinicians as adding something extra of value to the management position. This clinical integrity of the DM role plays an essential part in the engagement of clinicians with the organisation's objectives.

Engagement

One of the aims of the Australian Government's National Health and Hospitals Network Agreement is to have more involvement of 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, 2011). It is equally important to assess why engagement strategies are needed from the clinicians' viewpoint. This view further supports the need for involving clinicians in health system reform.

There are several compelling reasons to persist with an engagement strategy. First, clinician engagement has the potential to motivate individuals to be more involved in the organisation's processes (Spurgeon, Clark, et al., 2011). The literature also suggests that engaged employees perceive themselves as part of the whole organisation in which they work (Spurgeon, Clark, et al., 2011). The delivery and effectiveness of health care is dependent on the support and active engagement of clinicians, not only in their clinical activities but also in their management and leadership roles (Clark et al., 2008). In addition, Guthrie (2005) states that clinical engagement in health care organisations has resulted in better performing hospitals (Guthrie, 2005) and, according to Paller (2005) clinical engagement improves the financial bottom line of hospitals. It seems that engaged employees have a sense of satisfaction that has a positive effect on work performance, and this positive effect leads to improved organisational performance.

Second, we know that clinicians have a stronger allegiance to their profession than to the organisation in which they work (Fulop & Day, 2010; Kirkpatrick, Shelly, Dent, & Neogy, 2008; Kitchener, 2000). As a result of their professional allegiances and obligations, clinical engagement can only be achieved if efforts for engagement come from within their own profession — another doctor, who is a clinical expert. This is to say that trust and credibility to engage with the health reform agenda must come from within the medical profession,

rather than from those outside the clinician's collegial boundaries, such as managers. Therefore, in theory, the hybrid role of the DM is vital for successful engagement.

Third, clinicians have the responsibility for the delivery of services and the quality and safety of patient care (AMA, 2010). Therefore, clinicians need to have a good understanding of the impact of hospital performance targets on service delivery. Classically, doctors do not have a systems view of organisational work. Doctors are accountable for the care and safety of their individual patients at the operational level. However, changes to clinical practice at the strategic or tactical level of the organisation directly affect doctors' work practices, and therefore it is essential they take a helicopter view and are involved at all levels of organisational decision-making that affect the change process, not just their (small) operational part (Spurgeon, 2001).

Fourth, there is an organisational need to bridge the divide between managers and clinicians (Glouberman & Mintzberg, 2001). Doctors resent the continual health reform that has brought new structures of governance and cost controls to service delivery that is not synchronised with their clinical practice (Spurgeon, Clark, et al., 2011). For example, clinicians believe that managers are more focused on making decisions that meet prescribed performance targets than address the clinical priorities of health care (Crilly & Le Grand, 2004). Therefore, engaging doctors in organisational decision-making is essential for health reform because, when clinicians perceive they have little understanding of the health care change process, they are less likely to support health reform agendas (Council of Austrtalian Governments, 2011; Degeling & Carr, 2004; Spurgeon, Mazelan, & Barwell, 2011).

Hence, clinical engagement is a significant issue for health care organisations because when clinicians are engaged with health service reform, effective change policies are more likely to be successfully implemented which bring benefits to the overall performance of the organisation.

Thus far, we have explained what a hybrid DM role entails and why it exists. The purpose of this paper is to get a better understanding of how leadership by DMs is enacted through engagement strategies they use with their clinical colleagues that may influence organisational objectives being met.

METHOD

This research adopted a qualitative methodology to understand engagement strategies used by DMs in their leadership role, that influence organisational objectives being met and to make recommendations for practice.

The primary method of data collection involved semi-structured interviews with 18 DMs (doctors working in combined management and clinical roles) and five senior health service administrators (CEOs or General Managers), totalling 23. Recruitment criteria for participation included the participants having a knowledgeable experience as a DM or in managing a DM.

The DMs interviewed were all Heads of Departments, from a range of medical and surgical specialities. Their role as a DM included duties that ranged from budgets, staffing, quality control, performance management and rosters. Their management experiences ranged from six months to 10 years and they worked in their management role between 1 – 3 days per week and they worked in their clinical role 3 – 5 days per week. Twelve of the DMs interviewed had no management education and five had attended management development courses run through the Area Health Service or their specialty college. No DM interviewed had any university management qualifications.

The senior health service administrators held full time positions within the hospitals, and were responsible for the overall management of the hospital. No senior manager interviewed had any medical qualifications, although two senior managers had clinical backgrounds such as nursing and physiotherapy. Their management experience ranged from five to 25 years in a management role in health care organisations. One senior manager had an MBA, and the others had undergraduate university management qualifications.

The interviews were conducted over the period from October 1, 2009 to March 30, 2010, in several large hospitals within a large area health service in Sydney, Australia. Interviews lasted approximately one hour on average. The interview questions were broadly framed around the research participants' experiences and perceptions of the DM role. The health administrators were asked about their perceptions of how the DM role was enacted by incumbents and the DMs were asked about their experience and perceptions of their role as a DM.

The interview data was supplemented with observation and field notes were made from the researchers' observations while waiting for interviews, from the research participant's behaviour in the interviews, the research participant's interactions with other members of their department and from the researchers' observations when attending two department meetings. The data was coded and analysed for thematic content using the constant

comparative method of iterative inquiry to identify similarities and differences in the respondent's views (Boeije, 2000).

FINDINGS

The engagement strategies used by the DMs in this research appear to be paradoxical. On the one hand, when DMs are influenced by their professional identity, which is strongly anchored through a clinical perspective, their leadership strategy appears to maintain clinical dominance. On the other hand, when DMs are influenced by their understanding that they are both a manager and a clinician, their engagement strategy brings their colleagues together to meet managerial objectives.

Leadership through a hierarchical strategy

DM1 used his leadership role to engage clinical colleagues:

> I mostly do it [engage clinicians] by leadership. I am seen to be there listening, solving their [clinicians'] problems and getting them to help me solve mine.

DM 1's view is that being a DM allows him to be a conduit for solving both clinical problems and managerial problems. He indicates his leadership style encompasses a dyadic reciprocal approach between himself and his clinical colleagues (Howieson & Thiagarajah, 2011). Whilst he definitely indicates there is an individualistic gain by the expectation that his clinical colleagues will be involved with his managerial problems, he also indicates that he is available to help solve their problems. Such a reciprocal relationship allows DMs and clinicians to build a relationship based on helping one another as an engagement strategy.

In contrast DM 13 remarked:

> I like to lead by example to my colleagues.

DM 13's response illustrates that his leadership role is pivotal in his relationship with his clinical colleagues. His way of engaging his clinical colleagues is through his perception of himself as a role model. This was further supported by DM 10:

> As a senior member of the unit, I need to appear like a leader and to have a good understanding and a good relationship with my colleagues. Also, I

need to communicate well and that sets a good example for the rest of the unit.

DM 10's response demonstrates he engages clinicians through modelling leadership behaviour. His focus is on building collegial relationships through communication and modelling exemplary behaviour.

The above responses indicate that DMs may use behaviour modelling as a strategy to engage and motivate their clinical colleagues. However, such a strategy will only be effective if others decide to observe and emulate it. Gardner et al (2005) suggest that leaders who act as role models, through their words and their behaviour, have high levels of trust, engagement and wellbeing among followers. In this respect, DMs use their clinical position as an opportunity to build relationships with clinical colleagues based on their recognition of their clinical role rather than their management role. However, relationship building between DMs and clinical colleagues does not guarantee meeting organisational objectives.

Kippist and Fitzgerald (2009) suggest that the behaviour of DMs in their dual role is influenced by their professional identity (Fitzgerald, 2002; Lingard et al, 2002) seeing themselves as clinicians first and managers second. Professional identity refers to the construction of one's professional self, which includes professional duties, boundaries, objectives, values and assumptions. It is shaped by how an individual categorises him/herself professionally and how an individual categorises others professionally. Therefore, although DMs may model their behaviour through their leadership role, it may be questionable as to how effective such a strategy for engagement is. The effectiveness of such a strategy is worth questioning, because when DMs draw on their clinical values and beliefs to fulfil their DM role they reinforce their clinical individualistic view of being a manager. In this respect the DMs' behaviour can be understood through their behavioural control of clinicians.

DM 12 perceived he was a mediator between clinicians and managers:

> The younger new surgeons coming in [to the hospital] know they have to work through me with management.

DM 12's response suggests he distinguishes himself from the management community, emphasising the 'us and them' divide between clinicians and managers. Glouberman and Mintzberg (2001) refer to this divide as a horizontal cleavage separating those who work in the clinical domain from those who do not. The literature suggests that the goal of clinical engagement

is to promote a greater connection between the medical profession and their organisational environment (Baker & Denis, 2011; Ham, 2008; Spurgeon, Mazelan, et al., 2011). However, to achieve this aim, DMs are required to have a more collective and systemic view of their DM role (Baker & Denis, 2011). Therefore, when a DM uses his/her role to maintain the divide between clinicians and managers they further reinforce the practices, values and meanings that support medical dominance within the organisation (Degeling & Carr, 2004). Such a leadership strategy may not engage clinicians with the broader organisational objectives or shape their opinions in line with the organisation's change initiatives.

The discussion above suggests that DM engagement was from their perception of themselves in a hierarchical leadership position, using their professional identify as a doctor. In essence, these DMs used their clinical position of authority to enhance their own objectives with little reference to the organisation's goals or objectives. This means that DMs who use this strategy are less likely to motivate their clinical colleagues to be involved in the organisation's processes or objectives.

Leadership through a collaborative strategy

The large control that clinicians have over the content of their work highlights the importance of engaging them with the policy change initiatives that affect clinical service delivery. Hence, having DMs who have respect from their clinical colleagues and work from within the collegial group may be an important leadership and engagement strategy. Engagement strategies using collegial collaboration are demonstrated in the following responses.
DM 11 stated:

> I help them [clinical subordinates] to achieve [professionally] what they want to achieve. And there have been a lot of positive outcomes, from me working with them, you see in terms of their output.

His response suggests he works collaboratively with clinical colleagues toward improved clinical performance. DM11 suggests that his ability to collaborate with clinicians on their professional goals has a direct impact on their work outcomes. Such a strategy is built on a mentoring approach to leadership and engagement, rather than an authoritarian approach. Furthermore, working together allowed the clinicians to increase their output which has the potential to lead to improved organisational performance (Spurgeon, Clark, et al., 2011). Therefore, using mentoring as a leadership strategy provides an opportunity for clinicians to connect their clinical work to the broader organisation's goals. Furthermore, Guthrie (2005) suggests that DMs can draw on the competitive nature of clinicians by engaging with their professional goals as an opportunity

to increase organisational output. Clinicians like the opportunity to better their performance in comparison with other respected colleagues (Guthrie, 2005). As a result, using an engagement strategy that includes helping clinicians achieve their professional goals is appropriate if it means that the mentor directs those goals to fit within the broader organisational goals.

DM 2 uses collaborative strategies for engaging clinical subordinates:

> We [DM and team] work together to achieve the [organisation's] goals. This is the trust between colleagues.

DM 2's response demonstrates he fosters a team approach to engage clinical colleagues in collaboratively achieving the broader organisations goals. Macleod and Clarke (2009) suggest that that it is important to have a manager who is engaged with the organisation's goals before they can lead their employees. DM 2's response suggests he uses his role to facilitate clinical processes that have an effect beyond the confines of the department he manages. DM 2 promotes a common purpose between himself, his team and the organisation, demonstrating clinical engagement.

The literature suggests that formal quality improvement efforts require clinicians to support the goal of redesigning care and to participate in the team efforts to test and assess changes that support improved clinical outcomes (Baker & Denis, 2011; Berwick, 2003). The need for clinical support in organisational change further supports the argument for increased clinical leadership and engagement. Having more clinicians become directly involved in service change and innovation results in improved performance and productivity (Spurgeon, Clark, et al., 2011). Therefore, a collaborative style of engagement focuses the clinicians and the DMs beyond individual clinical practice toward the improvement of an entire health care system.

DM 12 uses negotiation skills to engage clinicians in service delivery issues:

> Around service delivery and planning, it has been about getting into the conversations [with clinical colleagues] and not always winning my side but coming to some sort of agreement at the end of the day, about how you are going to move forward from that point.

DM 12's response suggests that there are challenges in engaging clinicians when health reform initiatives directly impact clinical service delivery. The DM role spans clinical and managerial boundaries. This means that hybrid managers are at the forefront of implementing management directives that

will not always be seen as favourable by clinical colleagues. In other words, health reform policy may represent a distant reality from the day-to-day delivery of health care (Ham, 2003). Clinicians are often cynical of such policy initiatives and show little interest in their implementation (Spurgeon, Clark & Ham 2011). Therefore, engaging clinicians with such adverse changes requires DMs to negotiate with clinical colleagues on how they will collaboratively implement health reform policy. Hence, a leadership and engagement strategy through collaborative decision making may foster a more positive work environment that leads to improved work outcomes.

DM 10 supports a collaborative approach to engagement with clinical colleagues:

> I have learnt that I cannot make all the [management] decisions on my own. I need to think and consult with my colleagues, they are the experts in that area and I need to get their opinion.

His comments illustrate and confirm that clinical engagement draws on clinical expert opinion. His response demonstrates his ability to seek out more informed positions than his own. Clinicians will reject policy initiatives that limit their professional autonomy and professional good judgement over their clinical work practice (Spurgeon, Clark & Ham 2011). However, much of health care reform is focused on making clinicians more accountable for the resources they use. Therefore, a leadership strategy where DMs foster a supportive problem-sharing culture may lead to participative decision making and clinical engagement with organisational change initiatives.

DISCUSSION

This paper has highlighted engagement strategies used by DMs in their leadership role and has identified that there are differences in how DMs engage their clinical colleagues. Some DMs engage colleagues through their hierarchical leadership role, using strategies such as role modelling and position of clinical authority. Other DMs work collaboratively, using strategies such as relationship building and consultation with clinical colleagues.

Engagement strategies that focus on collaboration and negotiation help DMs and clinicians build a relationship based on mutual respect and trust that goes beyond clinical credibility to create a better alignment between clinical and managerial goals that focus on improving quality of care (Baker & Denis, 2011). Such engagement strategies work toward reducing differences between the clinical perspective and the managerial perspective of the organisational objectives.

Thus, it may be that these differences in engagement strategies play an important part in the organisational and individual outcomes of the leadership and engagement process. Therefore, although the role of the DM is crucial in leading health reform initiatives, the engagement strategies that the incumbents use appear to be an important factor in whether health reform initiatives and organisational objectives are met.

This paper also provides evidence that the challenge of engaging clinicians with organisational change objectives is more complex than just introducing the DM role with the expectation that the incumbents will naturally lead and engage clinicians with health reform initiatives. Instead, this paper has identified the need for managers to understand and appreciate that the professional identity of DMs can have a significant influence on how they perceive and enact their dual role.

There are human resource management (HRM) implications for recruitment and training that may influence how future DMs enact their dual role. First, there is a need for selective recruitment to the DM role. Recruiting individuals who have had management and or/leadership training to the role links individual competency and organisational needs (Leggat & Balding, 2013). In doing so, the organisation shows recognition that the DM role is part of the management collective and the importance of having a cadre of trained managers who can play an influential role as promoters of change. In addition, recognising management credentials as an essential requirement of the DM role also signifies to the medical community that the dual role is a potential career path for some clinicians.

Second, role clarity for the DM role is essential. A defined job description with clearly stated role responsibilities and accountabilities reduces the opportunity for role ambiguity for the incumbent. In doing so, it is more likely that DMs perceive themselves as a manager and a clinician, rather than a clinician and extend their clinical input by leading and shaping clinical service delivery at strategic and operational levels.

THEORETICAL IMPLICATIONS

This research builds and extends theory on clinical engagement by explaining how the professional identity of those who occupy the DM role influences their engagement strategies with clinical colleagues. On the one hand, when the professional identity of the DM dominates their perspective of how organisations should be organised, they engage their colleagues through a clinical frame of reference. Yet, maintaining this clinical dominance and

hierarchy may not always bring clinicians to understand the broader organisational perspective of health service delivery that is required for significant health reform to occur.

On the other hand, when DMs draw on a collaborative approach to engaging clinical colleagues, they foster a relationship based on cooperation and support for organisational change initiatives. Such a use of distributed or dispersed leadership styles to engage clinical colleagues reflects the professional bureaucracy of the medical professional and supports the notion of leadership from within. In this case, the strength of the professional bureaucracy is where clinicians feel they have input into organisational issues they may be less likely to undermine management objectives and work with health reform initiatives. Therefore, collaborative engagement strategies bring a better understanding of the organisation's objectives to clinicians and an active involvement in the required changes to clinical practice for health reform.

Our theoretical perspective of using the concept of professional identity to clinical leadership and engagement has highlighted enablers and barriers of clinical engagement that are a result of the ambiguity and paradoxes of the DM role.

PRACTICAL IMPLICATIONS

This research has practical implications for HRM and training for DMs. For example, the DM role appears to be enacted inconsistently by the incumbents. This may be a result of lack of clarity of roles, responsibility and accountability. Given that the DM role was intended to bring the business and practice of health together it requires more than putting a doctor into a combined management and clinical role.

DMs have a strong allegiance with their medical profession and their management perspective may be clouded by their clinical judgement and world view when the incumbent occupies the DM role. The challenge of the DM role is having those who occupy the role with the interest and ability of engaging clinical colleagues with the broader organisational context of health reform, rather than to protect medical dominance within health care organisations.

Having a clearly defined job description, with identified role responsibilities and accountabilities situates the DM role within the context and vision of the organisation. Role clarification would work towards making DMs accountable for their organisational outcomes. A   DM role situated within the

organisational decision making structure and processes would provide more support to those who occupy the role and fewer barriers in reaching the objectives of the organisation (Leggat & Balding, 2013).

Increasing the managerial profile within an organisation requires specific management training and/or education as an essential requirement in position descriptions and recruitment criteria when recruiting DMs. Healthcare organisations need to recognise and support the notion of recruiting DMs who have management education and leadership training (Kippist, 2012). Healthcare organisations need to actively recruit, support and foster clinical leadership competencies through organisational up-skilling processes so as DMs have the required management knowledge, skills and abilities to implement broader organisational change.

Improved recruitment practices for the DM role will result in health care organisations with individuals, who lead, facilitate transformation and encourage improvement within their service that directly contributes to the wider healthcare system. There are organisational benefits of having a cadre of DMs, with appropriate management and business skills who can contribute to the effectiveness and efficiency of the organisation.

Having HRM policies similar to those used when recruiting for other management positions in the organisation would benefit the organisation on two levels. First, it would ensure the individuals recruited for DM roles have the necessary management education and knowledge of business principles, as well as leadership skills required to engage and lead their clinical colleagues with the objectives of the organisation. Second, that prior to recruiting DMs, the job descriptions clearly identify the roles and the responsibilities of the incumbent.

The above practical implications of understanding engagement strategies used by DMs in their leadership role may influence how clinical practice aligns with the strategic direction of the organisation, as well as increase the likelihood of defined performance targets are met.

LIMITATIONS AND FUTURE RESEARCH

Due to the limited sample size and specific time that the research was conducted, there needs to be some caution acknowledged about generalising these findings to other organisations. For example, the focus of this research has been on exploring the role of the DM in an area health service in NSW, Australia in 2010. While this research lacks generalisability, it can be used when similarities are based on experiences with similar 'cases' without any

statistical inference (Stake, 1995). For example, as a profession, medicine offers similar parallels with other professions such as law and accounting. Similar experiences of academics working in universities or lawyers working in large legal practices may be used to generalise understanding about hybrid professional-managerial roles.

Future research on how DMs engage their clinical colleagues with performance targets such as ABF, implemented after this research, may extend the literature on clinical leadership and engagement.

In addition to engagement between DMs and clinicians, further research into how DMs and senior managers work toward meeting the demands of health reform would be beneficial. The management implications of ABF, such as 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 increasing government demands. This means that the relationship between DMs and managers becomes pivotal. Research into how DMs and senior managers engage with each other will extend the literature on clinical engagement at a senior level.

CONCLUSION

There is increasing demand for DMs to lead and engage their clinical colleagues to meet organisational objectives. This research has demonstrated that the paradoxes, which exist within the DM role, result in those who occupy the dual role needing to navigate on the one hand their professional values and beliefs and on the other hand, the organisation's objectives. Such inconsistencies and paradoxes emerge from within the organisation and the individual.

From within the organisation, this lack of clarity results in DMs defining their own role and making decisions about organisational problems (Kippist, 2012; Kippist & Fitzgerald, 2009). The ambiguity about the DM role has led to DMs being influenced by their professional identity and drawing on their clinical frame of reference of how their management role is organised and enacted. Lack of clarity of the DM role increases the likelihood of there being differences in the expectations and perceptions of the DM role, by the incumbents, the clinicians, and by senior managers. This ambiguity has the potential to create tensions between and among individuals (Kippist, 2012). Having clarity around the structure and content of the DM role may provide clear boundaries for DMs to execute their management duties and engage other clinicians with the strategic objectives of the organisation.

From the individual DM's perspective, their professional identity reinforces the practices, values and meanings that support medical dominance within the health care organisation. Such a strategy doesn't engage clinicians with the broader organisational objectives or shape their opinions in line with the organisation's change initiatives.

Finally, this research has illuminated the nuances of engagement between DMs and clinical colleagues. Increasing government pressure for cost reduction and organisational efficiency through ABF means that DMs need to engage clinical colleagues to understand and work more closely together to align clinical practice with the organisation's objectives to achieve defined performance targets. Highlighting nuances in the DM's engagement strategies allows a better understanding of the interactions and relationships between DMs and clinical colleagues within the Australian health reform perspective.

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