greater metropolitan clinical taskforce

Final Report

The medical clinician-management connect in greater metropolitan public hospitals in Sydney

Consultative meetings, October 2004

For some time there has been concern expressed in Ministerial, policy, and clinical and managerial circles about the relationships between clinicians and managers across the Australian health system. By consensus there is pressure on clinicians and managers and clinician-management relationships in contemporary health systems, and scope for these relationships to be improved.[i,] It is well known that this is an international problem.

On 17 August 2004 the Minister for Health, The Hon. Morris Iemma MP asked the Greater Metropolitan Clinical Taskforce (GMCT) to help with defining the issues specifically regarding relationships between hospital management and clinicians in New South Wales. It had been related to him that in some hospitals in greater metropolitan Sydney there was undue tension between these two groups. This might also manifest as conflict between area administrations and hospital clinicians or managers.

GMCT formed a working party comprising Kerry Goulston, Chair, John Dwyer, Graeme Stewart, Fred Kirsten, Jan Steen and Grahame Robards of GMCT and Jeffrey Braithwaite of the Centre for Clinical Governance Research at University of NSW to assess the scope of the project and design a response. In addressing this task the working party decided to conduct three working dinners of experienced clinicians and managers drawn from a range of metropolitan hospitals and area administrations.

To access relevant experience, initial emphasis was placed on involving senior medical clinicians (both visiting medical officers and staff specialists) and senior managers (such as hospital executive directors and directors of medical services). GMCT will schedule further meetings with allied health and nursing groups. The aim of the initial meetings was to define the key issues about the clinician-management connect, and catalogue proposed solutions to problems faced. To sharpen our focus, we looked at the way hospital clinicians and managers connect in greater metropolitan Sydney hospitals as a way of understanding the range of issues.

Synthesis of literature on the clinician-management connect

Much past international literature[ii,iii,iv,v,vi] has assessed the clinician-management connect. It shows that there are considerable challenges facing those who seek to address the differences and create harmonious, productive relationships. Key challenges recognised in the extant literature include:

- There are poor information systems on which to base decisions;[vii,viii,ix,x,xi]
- Multiple responsibilities are placed on those who are grappling with the clinical and resource dimensions of care simultaneously;[xii,xiii,xiv,xv]
- De-professionalisation by placing clinicians in management roles can occur;[xvi,xvii,xviii]
- Whatever management approach is taken there are difficulties inherent in managing autonomous professionals;[xix,xx]
- Ethical and other difficulties are faced by clinicians and clinician-managers in allocating and utilising resources;[xxi,xxii]
- There are strong needs for managerial training for clinician-managers;[xxiii,xxiv]

- There is effort and investment needed to improve the clinician-management connect;[xxv,xxvi,xxvii]
- The use of tools and approaches to improve the connect are needed, such as clinical pathways, joint quality improvement efforts, collaborative budget decision-making, evidence based approaches and utilisation review to manage processes, costs and outcomes;[xxviii,xxix,xxx,xxxi,xxxii]
- There will be various levels of resistance to change;[xxxiii,xxxiv] and
- There are deep-seated conflicts between managers and clinical professionals based on their roles, responsibilities, perspectives, values and training.[xxxv,xxxvi,xxxvii]

Method

Participants

A process to identify participants was invoked. A total of 106 invitations were issued, and 77 potential participants responded. Forty-seven participants (average age 50 years, range 33 to 68 years) were able to attend one of three sessions conducted in October 2004. There was a mix of females and males, and 75% of participants were medically qualified.

Almost half (n=25) of participants were clinicians with a managerial component to their work (eg they directed a clinical service or chaired a hospital division) with the remainder either non-clinical managers (n=8) or practising doctors with no formal management role (n=7). Eleven participants were current or past chairs of a medical staff council and five were current or past heads of University departments. There was a mix of backgrounds and experiences, and participants came from small and large hospitals and area administrative positions. Half the sample held a management qualification. Of the clinicians, their average clinical experience was 20.1 years (range 2-44 years) and of the non-clinical managers, their average management experience was 18.2 years.

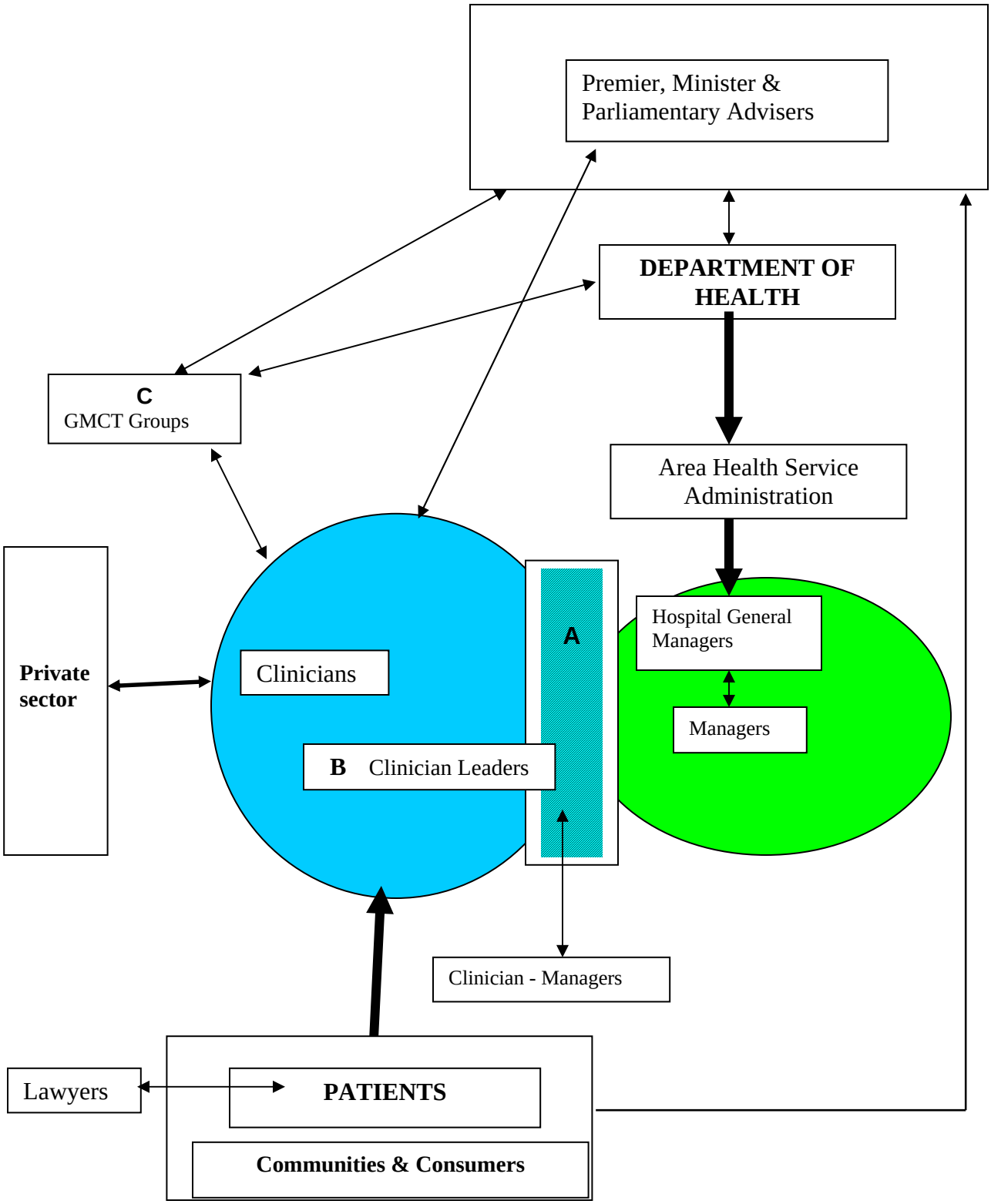
Consultative processes

Each consultative session was chaired by Kerry Goulston and facilitated by Jeffrey Braithwaite with Graeme Stewart, Fred Kirsten, Jan Steen and Grahame Robards from the working party providing input into discussions as they unfolded. Chatham House rules were invoked: that is, no participant's comments would be attributed to them, and confidentiality of individuals and their organisations was assured.

Sessions were structured so that each individual was given the opportunity to speak. They gave a general introduction to their background and clinician-management issues as they saw them. Then they participated in a general discussion of issues. Participants were later presented with a trigger – a modified schematic diagram of the health system, with the clinician-management connect highlighted (Figure 1). This provoked further analysis of the situation. After the issues were discussed, participants spoke to the solutions they thought could be adopted.

Discussions were open and forthright and at times passionate and forceful. All major points were recorded on a whiteboard and in handwritten notes and were then word-processed and prepared for subsequent content analysis.

Figure 1: Schematic of senior medical clinicians and managers at the public hospital level and the sources of pressure on their connect/disconnect



A: The Connect/Disconnect Zone contains full time managers, some with a clinical background & current clinicians with line management responsibility, some of whom are also clinician leaders
B: Clinician leaders include Chairs of Medical Staff Councils, Heads of University Departments & other highly respected colleagues, some of whom are also in line management positions
C: GMCT and its networks are seen by clinicians as the "Clinicians Committees"

Findings

We conducted a content analysis of the documentation we created of the discussions in two themes: key issues and potential solutions. Content analysis is a research technique to identify the most commonly occurring concepts in collections of textual documents. Once concepts are categorised in this way they can be quantified and analysed.

Participants generated 164 issues and 134 solutions. Tables 1 and 2 provide the top seven categories in each theme.

Table 1: Theme 1 – key issues facing the clinician-management connect

Category and number of comments	Exemplar comments
External influences beyond the hospital mitigate against effective clinician-management relationships (n=49)	▪ The system is defined elsewhere ▪ There's pressure from the hierarchy above the hospital ▪ Connections between hospital managers and clinicians are impeded by poorly coordinated communications, directions and mandates from NSW Health ▪ Area Health Services should let the managers manage ▪ Decisions of hospital committees go nowhere ▪ The real disconnect is at another level ie with senior management elsewhere ▪ Hospitals don't get budgets – they get financial allocations, and it is futile to argue against them ▪ Senior bureaucrats and politicians are at times involved in direct management issues
General comments (n=28)	▪ The vocational element of health has been lost ▪ We can only change things slowly, using influence ▪ People working in the hospital are its chief assets ▪ Yes let's have good decisions but not at the expense of democracy in the hospital ▪ You can't really go back to the good old days ▪ System impediments – only some problems can be fixed with money – and there are inefficiencies
Clinicians and managers have differing perspectives, training, views and positions (n=22)	▪ Clinicians have more independence and autonomy than do managers ▪ Clinicians have individual outcomes; managers can only make incremental changes to the system ▪ The timescale of success differs – clinicians deal with patients episodically, managers generally deal with longer-term issues ▪ The life expectancy of managers in their hospital role may be 2.5 years versus 25 years for a clinician ▪ Managers are more bound by the politics, doctors not so much ▪ Budget is the driving force for managers and clinical demands for clinicians; the two groups don't understand each other as don't have shared values or expectations
The disconnect is entrenched and sometimes adversarial (n=17)	▪ The disconnect between the two groups is based on a lack of understanding of roles and responsibilities. There are pressures on clinicians which don't allow them to see the pressures managers are under ▪ A proportion of time is spent on politics and managing the interfaces and reactive agendas rather than managing the issues ▪ A widespread view of clinicians is that they are often kept in the dark about budgets. Managers need to be open with clinicians. Clinicians would attempt to work within budget if they understood the issues

Category and number of comments	Exemplar comments
	▪ How budgets are managed creates mistrust – the battle and conflict is often over budget ▪ Realistically people are working with a fixed allocation of money ▪ Trust has been lost between managers and clinicians ▪ It is often easier to put up barriers than investigate the problem ▪ VMOs are often not so involved – it is hard to engage them. They run a business and want to know what's in it for them ▪ There is an issue of VMOs and the balance between their private and public interests
Clinicians' roles, problem-solving approaches, the problems they face and their applications of power are different from those of managers (n=16)	▪ Going outside, say to the Minister's office, is a real option to the clinicians ▪ Clinicians do have power but they use it very variably. Managers have limited direct power versus clinicians' indirect power ▪ Both groups may think that the other has the power ▪ Power exercised from above can de-rail existing local approaches to issues ▪ Clinicians are voting with their feet and shifting to the private system ▪ Loyalty – clinicians have it towards their patients but not so much towards management
Managers' roles, problem-solving approaches, the problems they face and their applications of power are different from those of clinicians (n=16)	▪ Managers face problems – performance contracts have benefits but strings attached and there are pressures from the AHSs and Department of Health ▪ Managers in hospitals need constantly to manage up the hierarchy ▪ Managers are locked in and are more insecure than clinicians ▪ Managers often lack executive capacity i.e. to make decisions, and to make them quickly ▪ Managers are obliged to stay within budget requirements ▪ Who gets fired? Managers not clinicians
Clinicians and managers in some places and on some issues are connected and do understand each other (n=16)	▪ The loyalty of people is to the institution not to the AHS or the entire system ▪ Progress with the connect depends on good healers ▪ Relationships can work if the shape and culture of the organization is right ▪ In some places there are relatively better communication structures than others, and clinicians acknowledge the role of managers, and managers productively work with clinicians ▪ Key issue of the connect: both groups share the same ambition – to provide services to the community ▪ Clinicians do understand you need leadership, good, productive culture

Table 2: Theme 2 – potential solutions to improve the clinician-management connect

Category	Exemplar comments
General comments (n=31)	▪ Be realistic about what we can achieve ▪ Can we create the light at the end of the tunnel? There a lot riding on it ▪ Private versus public interests represents a big problem ▪ The public sector is less endowed than private – this needs to be discussed ▪ We need to analyse why the system fails ▪ We also need to accept the limitations of the system ▪ We need to have a dialogue about demand, and definitely need community consultation and a debate about rationing

Category	Exemplar comments
Central solutions to reduce micromanagement and external demands from above, and let clinicians and managers get on with it, then hold them accountable (n=25)	▪ The hierarchy needs to empower clinicians and managers so they can make change ▪ There needs to be delineation of responsibility ▪ Managers are frightened of making decisions: they must be skilled; train them, and let them manage ▪ The problem with purchasers of health services is thinking they provide services – but they don't, the clinicians do ▪ Area administrations are a problem, but perhaps the larger, new Area configuration represents an opportunity to reduce micromanagement ▪ The 'us' and 'them' has genesis in the external health system 'out there' ▪ Individual clinicians and managers often get on well but hospital clinicians and managers as a group end up in conflict largely because of external pressures, i.e the conflict between clinicians and managers is forged by the system above ▪ The Health Department is a ministry of government with few shared values with health care providers ▪ People are very stressed reporting up rather than dealing with issues ▪ Micro-management is alive – what causes it and what can be done? ▪ Clarification of roles of people higher in the hierarchy is needed
Local solutions centred on engagement, finding common ground, improving trust, dealing with each other openly (n=19)	▪ Engage clinicians and managers through clinical service planning ▪ We must find common ground, stop working as individuals and work together ▪ A forum for clinicians and managers to get together is needed ▪ Trust and transparency of information are desirable attributes ▪ General managers should attend medical staff council meetings ▪ A common language, and the reinforcement of common interests would be beneficial ▪ A core problem is engaging clinicians with running services rather than individually providing them ▪ Forge a common agenda – find ways to do this ▪ Trust: this is the glue which binds relationships. How do we engender more? ▪ Dilution of VMO input needs to be reversed
Joint local and central solutions to define the respective responsibilities of clinicians and managers, hospital roles, and funding requirements (n=19)	▪ We need to define responsibilities and hospital roles – through clinical service plans, service definitions ▪ We need clarity, certainty and predictability over funding ▪ We should also recognise managers' experiences ▪ How do we rationalise hospitals such that it's politically palatable? ▪ Hospitals also need clarity in the locus of decision-making ▪ Politicians need to make some key decisions e.g. service rationalisation ▪ We should appoint more fulltime clinician-managers ▪ Qualifications for managers: we need to define what sort of managers we need. What skills and attributes are required?
Local solutions centred on rewarding clinicians and managers for participation on organisational processes (n=15)	▪ The health system needs collaboration not conflict ▪ Clinicians may want to do more in the public system say in January – but the system currently closes down in January ▪ Goals have to be written in conjunction with clinicians. It's got to be a collaborative process ▪ Encourage managers who involve clinicians ▪ An ongoing alliance between clinicians, managers and patients must be emphasised
Joint local and central	▪ We need financial incentives for clinicians to be involved, and need to change the way clinicians and managers work together so its not a

Category	Exemplar comments
solutions to provide incentives, information and infrastructure support (n=13)	financial disincentive ▪ Infrastructure support – such as IT, and clerical support re badly needed ▪ We need data provided so clinicians can make good decisions ▪ There needs to be an incentive for people to play a role – one incentive is financial, but that's not the only one ▪ There need to be incentives beyond monetary – and to involve other groups
Local solutions to train, educate and improve the understanding of each group's perspective and the requirements of local communities (n=12)	▪ Training and education – clinicians need an understanding of finance and management – and managers need an understanding of clinical processes ▪ Both groups need a very clear understanding with local communities ▪ We need better communication structures – not merely email ▪ Changes in clinical practice are needed to make the system more efficient ▪ DOH doesn't know where the hotspots are and there needs to be a discussion about where the resources are used ▪ We need to engender an Oregon-style debate, and have ongoing community consultation – this is critical, as we have not been able to rationalise services effectively ▪ How to reinvest in those at the frontline (clinicians and managers)? This is a crucial issue

Discussion

The nature of the connect

Concerns have been expressed that centre on the relationship between clinicians and managers in public hospitals. The problems have been identified in seven categories in Table 1, and seven solutions sets have been developed in Table 2.

The roles of clinicians, clinician-managers and administrative managers diverge quite considerably. There are significant differences in training, experience and perspectives. These differences can manifest as poor understanding of one another's point of view.

Several main themes are apparent. The perceptions of participants are as follows.

1. Decisions and directions often come from external sources before clinicians and managers are involved.
2. Power for decision making is commonly from above in the administrative hierarchy. This is often examined in variable ways, and sometimes with deleterious effects.
3. Clinicians and managers come to the decision making process from distinct viewpoints. It is perceived that managers come from the perspective of budget and clinicians from a clinical imperative. A need to determine common ground was a recurring theme at the meetings.
4. A significant issue was the identification of clinicians with hospitals rather than with Area Health Services, Senior Area Management or the Department of Health. The length of time associated with this commitment by clinicians, compared to the short average length of service of many senior managers, was also a factor in the relationships between the two groups.

5. Resource allocation, distribution and efficiency of use were significant concerns to clinicians. The need for transparency, provision of data that are relatively contemporaneous and honesty in discussions preceding decision making was regarded as fundamental in restoring trust between administrators and clinicians.
6. Political imperatives and the adversarial nature of approaches to provision of medical services within the system were seen as an impediment to meaningful discussions in many instances.
7. It was recognized that there were pressures on administrative managers which included performance agreements, budgets and hierarchical expectations. Issues seen as distractions by clinicians and mangers included demands, at short notice, for information required by the Department of Health, that were in reality only to be used as a defensive tool in the political debate.
8. Solutions, to be effective, will need to address short and long term issues, and local hospital concerns as well as external relationships which affect the connect in greater metropolitan hospitals.

Toward solutions

The consultative process highlighted many suggestions and solution possibilities. The main ones we have synthesised as follows.

1. Recognise that the major forces for discord between clinicians and managers lie outside their connect-disconnect zone: pressure on managers is largely from the Area administration and the Department of Health. Pressure on clinicians is largely from patient and community needs and expectations and such pressure may at times be compounded by political lobbying.
2. Recognise and address the effects of diminished trust and lack of common language between clinicians and the Department of Health.
3. Acknowledge the essential role played by clinician goodwill in holding together the public hospital system and develop clear strategies to protect and nurture it. This involves working on removing current barriers and an active program of rewards.
4. Fully define and address the factors that cause clinicians and managers to lose their commitment or leave the public system to work in the private system.
5. Acknowledge the skills of managers in holding together the public hospital system and develop clear strategies to protect and nurture this.
6. Acknowledge impediments from the State-Commonwealth divide and work on ways to minimise the difficulties caused by this divide.
7. Determine the best way to develop private and public hospital partnerships in the interest of clinicians and most importantly, patients.
8. Facilitate acceptance by both clinicians and managers of the need to acknowledge and manage together the limitations of the system. This would necessarily begin with openness and sharing of information.
9. Address the problems associated with the day to day connect between the Department of Health and clinicians. These include the stress of the degree of reporting up within the system at all levels, poor communication, direction and mandates from the Department and the time spent in providing information and data collection with little reference to patient care.

10. Provide better infrastructure support for clinicians and managers.
11. Reconsider the ways managers are dealt with and held accountable. Hospital and service managers need to be responsible for the performance of their part of the system, not unduly micro-managed, and need to be supported and provided with long-term contracts.
12. Define roles and responsibilities for hospitals. This should involve clinicians in consultation with management and the community. At a time of workforce shortage, clinicians are increasingly not prepared to take responsibility for services that they believe are inappropriate and unsafe.
13. Ensure clarity, certainty and predictability of funding. This would mean at least three to four years of certainty around funding levels and the opportunity for enhancements.

Conclusion

This report acknowledges the complexity of this issue and the long-term nature of strategies to address it. Some of the best organisations (the Virgin Companies based in Britain, Microsoft, headquartered in the United States of America, Semco of Brazil and BHP-Billiton in Australia) are grappling with this problem, and are making progress in engaging and aligning their professional and managerial staff's interests. Productive, collaborative working arrangements are a journey rather than a destination, but considerable progress is possible.

There were clear examples of clinicians and hospital managers working well together, and constructive suggestions were made to improve the connect. However the dominant theme is pressure both from above and from external sources.

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