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# The Value of Management Education for Hybrid Clinician Managers

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## ABSTRACT

Health care organisations have complex management structures with diverse professional groupings. To facilitate organisational decision making, many hospitals employ managers, also known as hybrid professionals, carrying both clinical and managerial responsibility. (Fitzgerald and Dufour 1998; Fitzgerald and Ferlie 2000; Iedema, Degeling et al. 2003; Lopopolo, Schafer et al. 2004).

This paper reports on current research that investigates the value of a specially developed clinical leadership program for a group of clinician/managers working in a teaching hospital in Australia. The findings include perceptions about changes to management skills and knowledge, interpersonal relationships and management decision outcomes as a result of undertaking this program. The conclusion is that, whilst a clinical leadership program is highly valued by participants, it also reinforces distinct professional boundaries that are the grounds for developing specialised clinical leadership programs for doctors. This raises questions about the concept of hybridity itself.

***Keywords*:** *Hybrid Professionals, Decision Making, Interpersonal Relationships,*

## INTRODUCTION

Health care organisations have complex management structures due to the unpredictable, highly changeable and resource intensive nature of work. In addition, health management is complex because of the tension between the business and the practice of health. This tension arises from major forces including increasing health expenditure and changing health needs of the population, advances in information and medical technology, governmental control, politics in health and the rise of powerful pressure groups (Zhan, Short et al. 2005).

Health reforms are demanding changes in the organisation of work requiring an increasing closer collaboration between professions to achieve the best clinical care (Iedema, Degeling et al. 2003). This has affected the managerial role to be a more facilitative function where clinical/professional and organisational responsibilities are recognized as being essential to achieving best practice (Fitzgerald, Lum et al. 2004).

Many health care services employ managers carrying both professional and managerial responsibility, these are sometimes referred to as hybrid professionals (Rees 1996; Fitzgerald and Dufour 1998; Forbes and Prime 1999; Fitzgerald and Ferlie 2000; Iedema, Degeling et al. 2003; Lopopolo, Schafer et al. 2004). These clinician/ managers have expert clinical knowledge, manage their professional colleagues, other health care professionals and organisational processes in their departments. The challenge for these clinical specialists is to manage dual professional roles within the organisational context (Allen 1995; Fitzgerald and Dufour 1998; Fitzgerald and Ferlie 2000; Iedema, Degeling et al. 2003; Lopopolo, Schafer et al. 2004). Hybrid clinician/managers are seen to have an important role in the health care environment, as they are at the intersection of the clinical and managerial domain within the reform agenda. Their role can be used to lead the required and appropriate improvement of effectiveness and efficiency of clinical service provision (Degeling, Kennedy et al. 2001). Hence, there is an expectation that hybrid clinician/managers balance clinical autonomy with transparent management accountability; understand the inter connections between financial and clinical dimensions of care; implement structures and practices to support a multidisciplinary clinical service

provision and clinical work must be within a domain of work process control (Degeling, Kennedy et al. 2001). However, these expectations are somewhat ambitious, especially when considering that, whilst clinical expertise is clearly related to high levels of education, hybrid clinician/managers often have limited or no training in their managerial role.

A major management responsibility is making decisions. In a health service, management decision making involves a range of different professionals. The experience from the United States shows hospital strategic decision making is improved when a diverse group of professionals, such as doctors, nurses and managers are involved in non clinical decision making (Anderson 1999; Ashmos 2000). This participative decision making model, meaning joint decision making, allows creative solutions to develop as each have the opportunity to gain a collective understanding from one another (Wood, Wallace et al. 2004). Participative decision making is not only seen to be valued by employees, it has also been shown to increase job satisfaction and affective organisational commitment (Scott-Ladd and Marshall 2004).

Managing participation is not simple, initially it can be seen as slow and messy, often leading to conflict. In addition, the ability to be inclusive and the use of a participative decision making process may be influenced by ones professional identity. Professional identity is characterised by how others see people in the profession, how people see themselves in the profession and how professionals view others in other professions (Fitzgerald 2002). Professional identity as a cultural manifestation of the structural characteristics of professions, may impact upon a profession's capacity or openness to change, as much as those structural characteristics do. Given that different professions have their own professional identity they will therefore have different ways of adapting to change and different ways of communicating through the change process (Fitzgerald 2002).

The literature from the United States, the United Kingdom, New Zealand and Australia all discuss the rise of the hybrid manager in health care settings. There are relevant points made in regards to the difficulties that arise from these roles when there is a lack of management education and training.

These include problems associated with professional identity such as having a “clinical” view of management (Fitzgerald and Dufour 1998; Iedema, Degeling et al. 2003), practicing individualistic decision making (Ashmos & Duchon), lack of awareness of others’ roles in the organisation (Ormond 1993) and poor communication with fellow team members (Lopopolo, Schafer et al. 2004).

Theoretically the benefit of working in a dual role is the ability to impact clinical work by controlling management managerial decision making. Hybrid clinician/managers are clinically up to date, and often seen as leaders in their profession. By interfacing managerial and clinical roles, hybrid clinicians, as clinical directors, appear to have greater acceptance of organisational reporting requirements, such as performance management and quality of care documentation (Fitzgerald and Dufour 1998).

Practically, Australian hybrid managers report that their limited understanding of the philosophies of organisational management and lack of management training, impedes organisational strategic planning (Iedema, Degeling et al. 2003; King, Kerridge et al. 2004). Thus, it appears that although managers recognize their need for management education, they do not necessarily action this need. This may be because clinical managers see themselves as doctors first and managers second.

In addition to the internal tension of being both a manager and a clinician, Australian hybrid clinicians mostly work part time in the clinical setting. This results in a low visibility to their staff and a low management presence (King, Kerridge et al. 2004). This may mean that either one or the other (or both) roles are not necessarily performed at their peak.

International literature shows there are benefits for doctors in hybrid roles to undertake management education (Owen and Phillips 2000; Atun 2003; Crosson 2003). Such benefits include an improved doctors’ understanding of management principles by giving them valuable insight into daily management situations and more tolerance of managers (Allen 1995; Fitzgerald and Dufour 1998; Nash, Laurence et al. 2003). In addition, changing the nature of a doctors’ engagement in

management processes may also change the nature of the organisation's political system (Buchanan, Jordan et al. 1997).

Ample literature supports the importance to have someone to stand effectively at the interface between practicing doctors and the realities of the health care organisation (Fitzgerald & Dufour 1998, Fitzgerald & Ferlie 2000, Iedema, Degeling, Braithwaite & White 2003, Bradford 1999, Lopopolo, Schafer & Nosse 2004). However, the challenge is to develop and support these clinical specialists as they move into leadership positions and manage these dual professional roles within the organisational context. Hence, we argue that management education for doctors, who have dual roles, is necessary to facilitate the functions associated with management responsibilities.

## MANAGEMENT EDUCATION FOR HYBRID MANAGERS

For the purpose of this research, management education is defined as the acquisition of knowledge, skills and attitudes of those people in organisations who have managerial roles and responsibilities (Kellie 2004).

Internationally, there have been a variety of management education programs for doctors to increase their management knowledge and skills through, for example, internal short courses and external certification and degrees (Loan-Clarke 1996; Walker and Morgan 1996; Edmonstone and Western 2002; Degeling and Carr 2004; Hewison and Griffiths 2004; Mintzberg 2004). In the United States and the United Kingdom medical students have the opportunity to include management as one of their science year options (Atun 2003; Crosson 2003). This allows students who are interested in medicine and management to appreciate key managerial and organisational issues that affect patient care prior to becoming hybrid managers.

In Australia and New Zealand, much of the management education is provided either through in-house training in health organisations or through outside educational institutions (Iedema, Degeling et al.

2003; Laurence, Wright et al. 2003), which is usually undertaken after medical training is complete. Management training is generally not undertaken until after clinical expertise has been achieved and when expert clinicians have taken on a managerial position. Presumably, this is because doctors see themselves as clinicians first and managers second, and management education is undertaken only after a managerial role is occupied. Therefore a managerial role itself is not necessarily seen as a career path, just part of the necessity to follow a distinguished *clinical* career path. This in itself reinforces that clinical work is 'real' work and the managerial role is secondary to clinical work. This poses the question: how valuable is management education to hybrid clinician/managers? This value of management education may be influenced by the relevance of context when learning.

Learning from experience, as in Experiential Based Learning (EBL), is one design of management education programs that ensures learning to be relevant (Boud and Walker 1998). EBL includes using group process to facilitate individual and groups learning about themselves and the group as they pass through a series of reflective processes. In addition, EBL uses a reflective process and requires effective facilitation to question and explore different ways of understanding (Newman 1995). In other words, through a reflective process the students become active learners.

This paper reports on initial findings of research currently underway in a large Health Service in Australia. The purpose of the research is to evaluate perceived differences in decision making; interpersonal relationships development and improved work outcomes, when clinicians who work in hybrid roles, have undertaken a management development program. For this we evaluated a leadership development program specifically designed for a clinical department managed by hybrid clinician/managers and supported by non-clinical managers. The program ran for a period of two and a half years. Initially the program focused on developing specific management skills of the participants, such as conflict resolution, performance management, grievance and discipline procedures and dealing with the more 'challenging' staff members. These topics were then followed by sessions that focused on the managers themselves, and included assessments such as the Myers Briggs Type Indicator (MBTI), Emotional Intelligence assessment and Leadership skills assessment. This research

investigates the perceived value of a clinical leadership program developed for this specific group of managers (including hybrid clinician/managers). In particular, it investigates 'if and how' interpersonal relationships change when the participants have undertaken management education, and to assess the perceived influence of such a program on managerial decision making.

## METHDOLOGY

The researchers used semi-structured interviews and participant observation. An analysis of the research material allowed for themes to emerge, as the interviewees constructed their own meanings of situations through the interview process.

The project involved all the program participants, their immediate staff, the program providers, the Health's Human Resource staff and senior managers. This resulted in a total of 14 participants, of whom 4 were hybrid clinician/managers. In addition, some participants were interviewed more than once as themes and more questions emerged.

Questions focused on the need, content, outcomes and future programs. Each interview was audio-taped and transcribed verbatim. QSR N-Vivo® software was used to aid detailed coding and analysis of the collected research material, facilitating the interpretation process. Through the analytic phase of the project, the research material was found to cluster around a number of core themes. To ensure consistency within each theme, codebooks were developed that included detailed descriptors of each theme, inclusion and exclusion criteria, and exemplars from the research material. Through a reflective, iterative process, theme content was interrogated to explore relationships between and within the themes. The process enabled the researchers to engage in a systematic method of analysis using an 'eclectic' process, whilst remaining open to alternative explanations for the findings (Creswell 1998).

We recognise that observational 'objectivity' is problematic. Our perceptions of the issues under investigation cannot claim *exclusive* privilege in the representation of those issues. However, to ensure that diverse perceptions were reflected in the research material, regular meetings were held to provide the research team with a forum in which to discuss the research material and their interpretations. Additionally, the authors made use of documents such as minutes of meetings and policy/procedure changes (Veal, 2005), as well as biographies, in the form of participants' own written accounts, were kept by some participants as documentary evidence. Finally, the interactions between staff in the department as well as the physical environments were observed. These strategies provided us with important opportunities to create, check, and recreate meaning from observations and impressions, constantly reflecting on our own biases.

## A MANAGEMENT DEVELOPMENT PROGRAM EVALUATED

Responses from interviewees about the program were positive. The purpose to learn management skills and update management knowledge was seen as a distinguishing feature and strength of the program. Spending dedicated time each month allowed the participants to communicate with one another on a meaningful level. Increased communication with one another also lead to building strong relationships with each other and the participants found that they learnt more about respect, trust and values of other members of the participants.

Using an experiential based learning approach, where the participants used workplace experiences to reflect on newly gained skills in their context, was perceived to be valuable. A doctor, who is also a managers stated:

> *" ……we could talk about particular scenarios that were bothering us at work, so a particular management issue that we were having trouble with.…….…… got input from the group."*

It can be said that despite the obvious weakness of homogeneity, this group's experience of this kind of peer mentoring has had a positive effect on workplace atmosphere.

The program was equally highly valued by senior executives in the hospital. An Executive stated:

> *"…. since the Program has commenced, some of the participants have adopted a different attitude to work and to each other".*

Prior to the program the department has been a silo of activity, as for now the department interacts much more with the organisation as a whole. The Executive stated:

> "*They now send their things off to be signed to me instead of the Area Head. That means they are able to have things signed off earlier than before."*

The program has had a desired effect of a greater understanding of hospital systems and appropriate communication lines. This may result in a smoother decision making process and faster returns on requests and is an area for further exploration.

In addition to positive responses from participants and hospital senior executives, the facilitator expressed satisfaction with the achievement of the program objectives. The facilitator was particularly pleased with the interactional changes and noticed "*a significant reduction in feelings of antagonism and conflict within the group".*

Thus, it was reported that the program benefited both participants and organisation. The participants benefited through the use of EBL where they used current workplace situations in their learning of new management skills and knowledge and transferred those skills back to the workplace. The organisation benefited by the groups increased communication skills that were used outside of their department in other areas of the organisation. In addition, the program was a successful venture for the facilitator who felt that there was a noticeable change in how the group communicated with each other.

***Management Skills and Knowledge***

Focusing on specific management skills was seen as particularly helpful to the members of the group who had not attended any management programs before. A doctor who is also a manager said:

"*Doctors are not trained to be managers at all. I have not had 5 minutes of management training let alone a devoted year, so from my perspective I thought it [the program] was very important.*"

This statement confirms that this doctor didn't think of gaining managerial skills until appointed into a managerial position.

During the course the facilitator of the group used videos, management theory and encouraged the participants to use specific cases from the department making the program relevant to their situation. This was seen by the facilitator and non clinical managers in the group as a necessary way of keeping the clinician/managers interested in the program. A manager who is not a doctor stated:

*"If it's too fuzzy, if there's not intellectual input, they will just lose interest and go away. It needs direction and a facilitator."*

This suggests that clinician managers respond well to an experiential based learning approach to management education.

When asked whether doctors who are managers would attend a Management Development Program joining all general staff, one doctor said:

"*I think there is some sort of management program run in the Area, however, I don't think it is for doctors. Its best if doctors to have their own program, they would go to that because they would feel special."*

This would indicate that doctors see themselves as different from other professionals working in the health care industry. It may also mean that when doctors are made to feel 'special', the likelihood of a higher level of motivation for engagement is reached.

***Interpersonal Relationships***

It was reported that once the group became more comfortable with one another, the facilitator focused on the participants themselves. The use of Myers Briggs Type Indicator was seen by the group as a helpful way of understanding other members and their staff. A doctor, who is also a manager stated:

"*It also made me understand the other managers that I am working with, to understand where they are coming from."*

There was a strong feeling among the participants that understanding others participants' personality types enabled them to understand their views. A manager who is not a doctor said:

"*It's a lot easier now; we don't have the tension like the early stages of the Program. People can relate easier to one another and I don't pick up the same tension before the meeting is about to start."*

It appears that as the group spent time together and shared experiences they developed a sense of trust reducing group tension. In addition, the facilitator of the program noticed a "*turning point*" in the sessions that focused on the group interaction. In particular, the facilitator noted that group members *"Became more engaged with each other and with the program"* when they started to learn about each other and how the dynamics of the group were influenced by the member's personalities. The MBTI helped with understanding individuals' preferences and reflect on incidences that could be explained by type indicators. For example, introverted managers are likely to work outside their comfort zone, when publicly defending the department in certain situations. Equally, some preference types are naturally more systematic than others. Understanding each others' preferences could create an opportunity for altering the current division of labour. However, this opportunity has not yet been explored because it seems that role differentiation is strongly historically anchored and very difficult to change.

At the same time, the participants reported that they were not well supported at the senior executive level. In fact, the group believed their development had gone beyond the development of other management teams, including their managers. A doctor, who is a manager said:

"*I suppose it would be useful at a Senior Management level to have a common forum similar to what we had and to talk about heart to heart issues; I think that would be useful."*

As the participants developed stronger relationships with each other they were aware of the lack of support from their senior executives. However, there was no suggestion as to how to tackle this as a group and this creates another opportunity for the facilitator to address. Thus, the program had a

reportedly positive effect on the participant's relationships and how they communicate with each other. However, it appears that special treatment of one particular group also somewhat bounds and isolates this group as they perceived their developmental stage to be advanced. This is potentially problematic as by solving one problem another is created. The broader organisational opportunities created by a leadership skills program for specific organisational groups are not yet explored.

***Management Decision Outcomes***

As the group developed stronger relationships, it appears that they shared more information with each other and participated in the Executive meetings more openly. A manager, who is not a doctor said:

> *"People are participating and are informed more. Before there was a reluctance to talk, some people wouldn't talk to other people."*

From interview analysis, it appeared that participation in the management development program gave group members the skills and trust to participate more in the group decision making than before, because participants felt more comfortable speaking out at meetings and to participate in the decision making process.

However, when researchers returned a few months later for a 'reporting back and consolidation session' our observations contradicted the espoused high value of the program. Whilst importance of the program and its high value was supported by the director, this clinician/manager participated minimally at this consolidation meeting. He was called away to do, as he called it '*real work*'. During this meeting the group was presented with preliminary findings. One doctor expressed his dissatisfaction with the absence of the director. He stated: *"I've given up having lunch with the other doctors of my team to come to the meeting today."* This comment highlights that doctors in hybrid roles see their relationships with clinicians as being very important. In addition, this comment could imply that his attendance at this meeting was influenced by his expectation that the director (who is a manager and a highly valued clinician) was going to be there, which raises questions about motivation for undertaking a leadership program. It was also interesting to note that medical clinician/managers were the most vocal. The questionable motivation and apparent dominance of medical clinician

managers in this meeting may signify a difficulty in achieving true participative decision making. Thus, whilst the leadership program was set up to bring about more collaboration within the group, in reality, the group was still experiencing effects of existing and strongly reinforced professional boundaries (Fitzgerald, 2002). Professional boundaries are enhanced by the organisation by, for example, setting up a leadership program that makes doctors in particular feel special. At the same time, participants allow medical dominance to hold by allowing doctors to dominate a meeting. Although participation at meetings were 'expected', the director allowed himself to be called away to "to real work". This was minimally criticised by the group, and the person who commented on the absence did not do so to indicate the director's value in adding to the meeting, but was more annoyed that he himself was therefore less noticed to be present. In addition, he had lost an opportunity to confer with his clinical colleagues.

Participants vented their frustration with not being able to make financial decisions for their department as a result of bureaucratic processes. One participant stated:

> *"Well here you are charged with a whole lot of responsibility, but, you are not allowed to make any decisions without checking with 15 different people first."*

Thus, at one level they felt the decision making process had improved within their own department mainly due to improved interpersonal relationships, yet the decision making process had also increased their frustration at not being able to make decisions that would influence outcomes for their department. This is another avenue for exploration. The mismatch between departmental and organisational goals is evidently an issue that will influence the success of departmental management development programs. The program, partly through the participants' increased awareness of organisational processes, seemed to increase the participant's frustration with the organisation decision making process, rather than eased it.

Apart from the methodological limitations already outlined, we do not profess that the findings of this research can be generalized to other management development or leadership programs. However,

through evaluation of this particular program some important issues have come to light that warrants further thinking about value of management education programs for specific professional groups.

## CONCLUSIONS AND FURTHER RESEARCH

This paper sets out an argument that clinician/managers who work in dual clinical and management positions have little or no management education or training. It appears that management education does not seem to be important to clinician/managers until there is a specific need.

Findings of this research indicate that when clinician/managers participate in management education, the management knowledge and skills gain are transferred back to their workplace giving the participants increased confidence in their management roles. Also, when clinician/managers gain understanding of personality indicators, they gain increased understanding of themselves and others which was reported to improve communication and interpersonal skills and enabled them to develop a deeper level of trust.

Finally, reportedly as trust develops there is more information sharing and this enhances decision making processes. However, this process also emphasized that improved cohesion within a group does not necessarily improve organisational decision making.

This research has identified that management education and skills are important personal attributes in the selection criteria for clinician/managers. This may have broader organisational implications, where the practice of placing doctors, who have excellent clinical skills in management roles without management education and skills, may need to be reviewed. If clinician/managers are going to continue to be employed in health care organisations without previous management education or experience, the organisation may need to address management education for clinician/managers early in the management role and not left until, as in this particular group, there is a crisis in the department. In other words, the organisation has an important role in supporting clinician/managers from the time they start their management roles.

Although this paper indicates that management education for hybrid clinician/managers is necessary to facilitate the functions associated with management responsibilities, it is suggested that further qualitative research into the best way to engage this group of managers. This would allow further exploration of what is most valuable to the health care organisation when developing management development programs particularly in regard to participative decision making processes and opportunities for altering the current divisions on labor in health care organisations.

We argue that long term effects of special management and leadership program for doctors must be considered. Their professional identity, influenced through medical training and socialisation into the profession, already allows doctors to see themselves differently to other professionals in health care. In addition, the organisational response reinforces bounded professional identity construction. 'Special' treatment of doctors may impact on how doctors view managers, their careers and their management education. This may impede collaborative decision making practice and reinforce the distance between clinical and managerial roles. The tension lies between offering management education that engages doctors in a way that keeps them motivated to become good managers, and ensuring doctor managers learn to engage in participative decision making for which they need to understand diverse organisational roles. Whilst a program may be targeted and valuable to hybrid clinician/managers, it is questionable if special treatment of a doctor-oriented management development program is equally valuable to non clinical managers.

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