Opinion paper

Managing professionals: The otherness of hospitals

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Received: 12th October 2009

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Introduction

Systematic management development — a standard process in many large companies nowadays — is still rarely practised in hospitals. It is still unusual to find hospitals that invest in management. While management programmes are provided by various institutions, they are mostly of a singular nature and have little connection with the objectives and strategic intentions of the organisation in question. The reasons for this are many and varied. Two of the most important reasons are the fact that management competence has been a low priority for such institutions to date, and the even lower availability of management programmes specifically designed for hospitals. The first reason is attributable to the fact that, until only a few years ago, management and positioning issues to be tackled were few and far between. There was therefore little need to specify management and management competence for the hospital organisation. Secondly, and as a result of this, management as a discipline neglected the unique nature and special characteristics of this type of organisation. Hospital management has been understood as practising health economics. The specific organisation of hospitals and its challenges for management has only recently been highlighted by related studies.[1–5]

We hypothesise that hospitals are truly different and that their otherness is not well understood by the management experts or by the public. This otherness is defined by an exceptionally strong internal differentiation. Glouberman and Mintzberg have demonstrated this using a model: the so-called 'hospital cross' (Figure 1).[6] The differentiation of the four quadrants, cure, care, control and community, each with its own languages, forms and cultures, points to the challenges entailed in the overall management of such an organisation. The task is to focus consistently on the new, prevent the immediate activation of subsystem-specific immune systems, and remain in constructive cooperation. In particular, the (unavoidable and progressive) economisation of hospitals (eg by diagnosis-related groups) makes it even more challenging to surmount the horizontal barrier — the so-called 'clinical divide' — between the 'core business' and 'management'. This barrier constitutes a major obstacle, and every doctor, nurse and hospital manager has his or

DOI: 10.1179/175330310X12665775636427

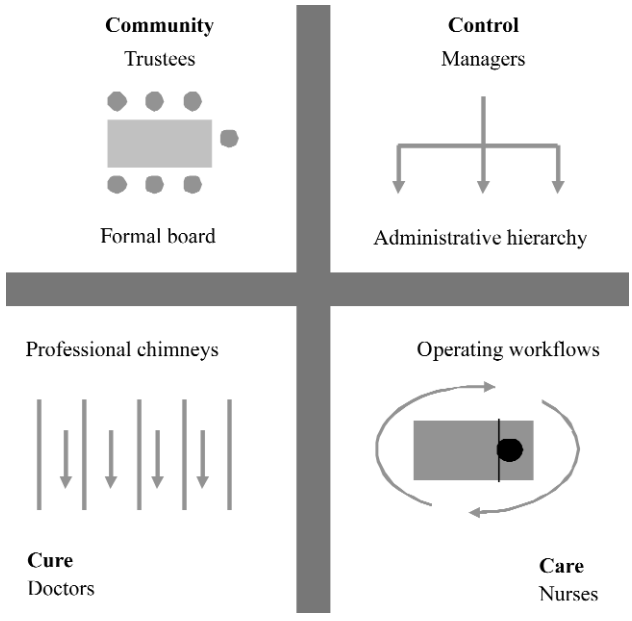

Figure 1: Differentiation of hospitals

her own experiences to relate in this context. Only a deep understanding of this context and appropriate management skills enable management to be successful. If this is not the case, conflict-ridden or paralysed systems will emerge.

We believe that this pronounced differentiation corresponds to the loose relationship between profession (medicine) and organisation. Doctors in particular are largely trained and assigned to the social order by professional values — and not by the organisation. As such, they tend to identify more with their specialty or discipline than with the organisation — 'the firm'. This primacy of the profession has its advantages. A surgeon can perform routine operations in any hospital, and an operating theatre is virtually the same wherever it is located. The principles of anaesthesia are essentially the same whether they are practised in Berne, Paris or Houston, and so on. Medicine is largely professionally-defined — and hence relatively independent of concrete institutions. To date, therefore, hospitals have tended to resemble a collection of relatively autonomous clinics or departments rather than acting as organisations in the modern management-centric sense of the term. Yet they still function.

Managing professionals: Differing understandings of leadership

We recently undertook a study in cooperation with N. Endrissat and W. R. Müller of the University of Basel's Department of Business & Economics to investigate hospital managers' and chief physicians' understanding of leadership. The study threw light on the so-called 'clinical divide' created by the precarious differences between the core

business and management. Using a qualitative research approach based on narrative interviews, we interviewed 15 hospital managers from different institutions and 15 chief physicians also from different institutions and in different disciplines.[7,8] The interviews were evaluated and validated in several steps with the aim of identifying the common leadership topics and recurring themes within the varying understandings of leadership by each professional group, and in so doing we obtained a group-specific interpretation of how leadership is viewed and understood.

The understanding of leadership

Hospital managers (Figure 2) view themselves as responsible and accountable for the hospital in its political context and for its future as a whole, particularly in economic and strategic terms. As such, they form a counterweight to the local, case-driven operational orientation of professional clinical staff. For them, leadership largely means establishing trustworthy relationships, primarily in order to achieve the requisite gravitas and acceptance for themselves and their concerns; but also in order to engage the hospital's professional (clinical) executives in addressing overarching issues and to simplify and integrate the fragmented and complex professional structures. They seek to gain trust and respect through clear, consistent and committed actions. They also endeavour to integrate and align the organisation by designing participative, consultative processes or to profile themselves through objective, transparent decisions and in so doing get their own point of view across. Hospital managers have to contend with a pronounced professional culture and a complicated, heterogeneous structure, as well as a difficult political environment. This gives rise to a unique ambivalence between an emphasis on the slow design of development

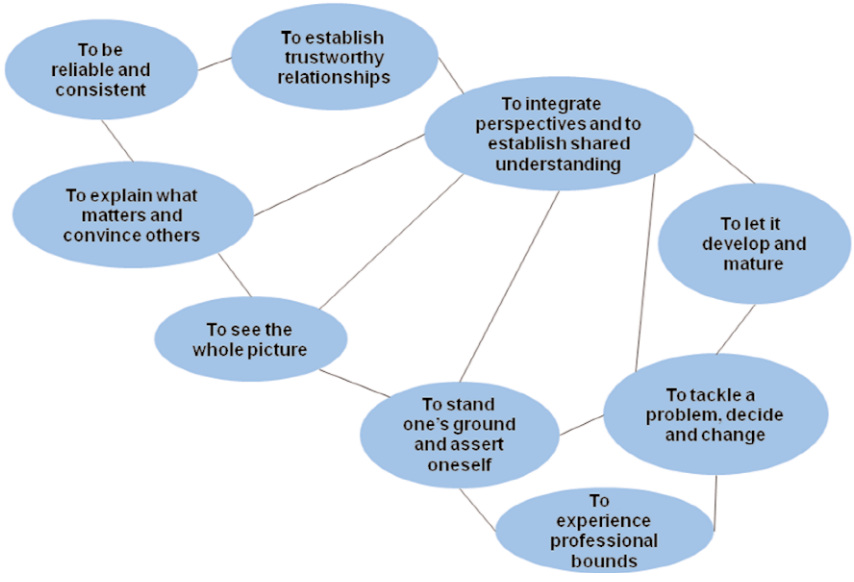

Figure 2: Leadership attitudes of hospital managers

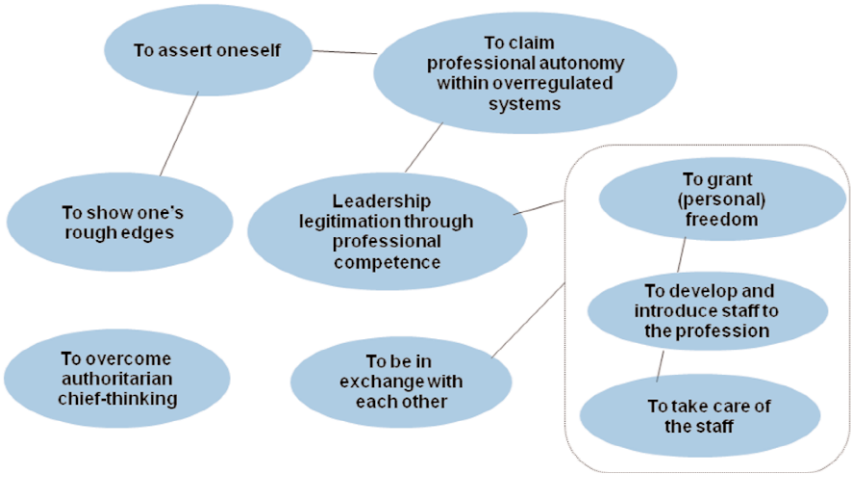

Figure 3: Leadership attitudes of chief physicians

processes on the one hand, and the rapid implementation of changes they view as essential on the other.

Due to their professional competence, chief physicians (Figure 3) regard themselves as responsible and accountable for the actual core business of the hospital: qualified patient care. Their perspective is therefore case-related and disciplinary rather than institutional. Their priority is patient work, not least in order to maintain their own professionalism, and they manage their clinic as a pool of professional co-workers. For them, leadership primarily means deploying staff while simultaneously developing their co-workers' professionalism by instilling in them professional values, attitudes, know-how and skills — or facilitating the acquisition of such attributes. They believe this 'educational' role is legitimised by their extensive professional experience and the sound qualifications they have acquired in the process, in addition to their clear personal position. Their exclusive legitimation is based on their autonomy in their own field, which they believe is under growing threat from institutional and, in particular, economic developments in the (political) context. The efforts of hospital managers to implement an overall perspective and achieve more institutional integration contradict their own understanding of the claim to autonomy which is grounded in professionalism. They want to pursue their leadership task by creating an environment that encourages personal development and provides room for professional emancipation, acting as role models, engaging in and organising the transfer of experience and knowledge and endeavouring to ensure the security and support required for development by forging caring relationships. Their understanding of leadership is strongly personal rather than based on structures and formal instruments. This calls for a clear personal profile which, by its nature, may also impede a close relationship with others.

We believe that these differences in the two understandings of leadership are highly relevant. Above all, there is the prominent position that experiences and incidents with chief physicians take in the tales and

recollections of hospital managers. The situation is different with chief physicians. Their narratives rarely, if ever, mention hospital managers. Here an imbalance of perception can be identified. The absence of any mention of hospital managers by no way means that they are not accepted by chief physicians. Rather, they focus on other roles and experiences that have a higher relevance for them. Accordingly, hospital managers find it difficult to position themselves as the leader responsible for the organisation.

Compared with other professional groups, hospital managers rely strongly on networking and on forging relationships, and seek to integrate different subsystems and perspectives in their hospitals. In contrast, physicians are more focused on and interested in professional autonomy as they feel restricted by what they view as an over-regulated system that stops them from claiming their professional autonomy. Relationships are of second priority, while professionalism is at the forefront. In contrast, the key priority for hospital managers is to pursue and practise trustworthy relationships: an appreciation of values, credibility, trust etc. Thus, while physicians fight for their autonomy and try to assert their personality, others strive to focus on the quality of relationships and on greater integration. We see this as two opposing 'models': the chief physician, who freely admits to a certain degree of non-conformity, and the hospital manager, who is more strongly influenced by the expectations of others and must 'regulate' himself or herself accordingly. Whereas chief physicians like to convey an image of distinctiveness, expose their personal traits and are not afraid to make unpleasant decisions, hospital managers are much more 'politically' driven, exerting their influence in particular through conscious deliberation and weighing up the opportunities and possibilities provided by specific constellations of actors and networks.

One can assume in this context that complementarities, in the sense of differing functionalities, are a given. In our opinion, however, this diversity of perspectives reveals a few potential stumbling blocks, ie the potential for misunderstanding or acting at cross-purposes, with the associated risk of conflict, as so often happens in intercultural contacts. People 'misread' each other, misunderstand each other, and through such misinterpretations devalue each other and end up in a dysfunctional loop.

The discovery of management development

Traditionally, low priority was given to management and leadership development in hospitals. This is understandable, as for many years each professional group has concentrated on its own understanding of management and has established its own executive staff training schemes. When it comes to stronger and overarching leadership, the need is for management skills and/or cultures which do not stop at the aforementioned barrier, ie the 'clinical divide', but in contrast effectively integrate the various subsystems.[9,10] This necessitates, for example, an ability to balance the requirements for an overall organisational focus with the requirements for professional autonomy.[11–13] This is the only

way in which individual patients can be professionally cared for while, simultaneously, the organisation as a whole can be managed successfully. In our opinion, this is the primary goal of any successful leadership development in hospitals. Networking capability, interdisciplinary cooperation etc are therefore key competences that must be acquired by executive staff — managerial as well as clinical. This calls for an understanding and knowledge of the diversity of cultures and subsystems, and practical application of such understanding in hospital-specific and effective communication, processes and project architectures. It necessitates knowledge of the relevant contexts and a goal-driven ability to bring together the various disciplines, professions and units.

As such, leadership in hospitals is far more than just the integration of health economics and management know-how: it means the ongoing integration of complex, unique and often contradictory contexts with due consideration to the characteristics of largely decentralised (expert) organisations with their diffuse balances of power, multiple value systems and strong claims on autonomy by key actors.[3,14] This is especially true of university (teaching) hospitals, which — unlike any other organisation — are obliged to bundle various social subsystems (politics, healthcare, science, education etc) under one roof.

We conclude that managing hospitals successfully means generating an understanding of how to manage such complexity beyond simple, conventional management techniques. The requirements are high, and gone are the days when merely promoting 'strong management' was all it took. The goal now must be integrated leadership that can handle multiple contexts sensitively, and at the same time, carry out its key tasks — steering and development — effectively. A crucial step is to develop these leadership competencies in-house — multi-professional and cross-functional. Such leadership training strengthens personal development and makes an important contribution to the equally crucial development of the institution's culture. Competencies, attitudes, skills and culture must go hand in hand. In the future, those hospitals that successfully build such leadership will outperform the others.

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