Inform

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Healthcare tribes and the circling medical clans - Nurses should take more of a lead in contemporary healthcare organisations

Rod Perkins, Senior Lecturer in Health Management at the University of Auckland, drew strong support from our June Eurest seminar audience for his argument in support of a proposition "that nurses should be over represented in the higher echelons of health management in New Zealand, Australia and the UK." In opening his presentation Rod was quick to affirm that his intent was not to undervalue the contribution of the medical profession, or any other health professionals, to the health and well being of our society. Rather, he was in the process of developing an argument in favour of nurses taking leadership roles in organisations with the emphasis being on organisations, as taking leadership in health care organisations was different from taking leadership in health. Rod is still working on his argument and would welcome feedback at r.perkins@auckland.ac.nz

Rod Perkins

He began, "today organisations are much more important in healthcare delivery than they were in the past. Primary care is no longer based on individuals, it is now based on groups; hospitals have become more complex over the past 20 years; and there are a wide variety of public, private and voluntary organisations in the makeup of health care.

The roles of management and leadership in contemporary health care organisations is to meet the health needs of communities in association with other agencies and within available resources. To fulfil this role we appoint managers who will concern themselves with delivering accessible, high quality and cost effective services. The question is, where should these people come from? The options are to draw them from medical ranks, nursing ranks, allied health professionals, or from outside the sector altogether.

Pieter Degeling, now a Professor at Durham University, is interested in tribes and sub cultures. Peter's view of healthcare organisations engaged in the delivery side of healthcare is based on a "conventional healthcare organisation model" with a large nursing tribe, a smaller administration tribe and a tiny group of allied health professionals, who make their contribution but from a tribal view they are not a solid group like the others are. (see Figure 1) These tribes are surrounded by the "warring clans of medicine" who will continue to fight bitterly with each other until some one from one of the tribes picks on any one, then all the dots join up and they become another tribe. This has had quite an influence on my thinking on health care organisations and who should lead them, given all the things taking place in society at present.

Conventional Healthcare Organisation

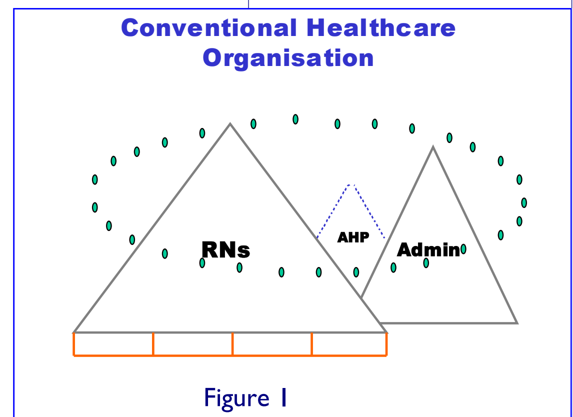

Figure 1

My first argument is to consider health care organisations and their behaviour from an

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organisational theory perspective. Quickly looking at the major theories that have application and identifying the school of thought and the metaphor used to describe them, first, we have scientific or classical management theory which sees the organisation as a machine; then the human relations theory—which sees the organisation as a supportive community; followed by the systems/contingency theory which sees the organisation as a biological organism and the organisation as a contingent/adaptive system; and finally the critical theory which sees the organisation as a system of domination. This last one is a notion where to understand the organisation you have to understand who dominates who, it is not just about how, it is about all the things taken as given which we don't talk about.

My first proposition is that critical theory continues to apply in health care organisations. From this flow two further propositions. First, people that are managed or led should not feel dominated by their managers or leaders because you won't get the best out of them if they do so feel; and secondly, as a subculture, doctors do not feel threatened by nurses whereas doctors tend to feel dominated by accountants, when accountants get on top. Many of you will have observed how some people operating under the framework of accountancy, economics or business will unsettle the medical professions.

The argument doesn't end there. My second argument invites you to consider some of the key leadership qualities required in health care organisations. In this, Daniel Goleman has influenced me. Goleman may be new to you, he writes about emotional intelligence – something you would not talk about in the 90's when the terms "purchaser and provider", "competition", "winning and losing" and so forth were popular. Goleman talks about emotional leadership and I believe there is a linkage here. I came to this position by talking to Ron Dunham, the CEO of Bay of Plenty DHB who led me to the reading of Goleman.

Goleman wrote an article in the Harvard Business Review (*Leadership that gets results, HBR Mar-Apr 2000*) in which he talks about the ability to manage ourselves and our relationships effectively through four fundamental capabilities: self awareness; self management; social awareness; and social skill. These may seem kind of "soft things" but there is increasing awareness and interest around them.

First of all, self awareness is about emotional self awareness, being able to read and understand emotions and recognise their impact on work and then be accurately able to assess ourselves, our strengths and weaknesses, coupled with self confidence – a positive and strong sense of worth.

Self management entails self control, trustworthiness, conscientiousness, being able to adapt, achievement orientation and initiative. Social skills includes; visionary leadership, influence, developing others, communication, change catalyst, conflict management, building bonds, teamwork and collaboration, with communication and managing conflict being the most important.

I really paused when reading Goleman's stuff on social awareness and the notion of empathy and the skill at sensing other peoples emotions, understanding their perspectives and taking an active interest in their concerns. I will come back to this later as there is a certain sort of knowledge that nurses have which has come out of research Pieter Degeling has done. He calls it "situated knowledge" which is knowledge that arises out of a concern about the situation that people find themselves in. That is in the terms of his research, patients, but that same knowledge can apply within an organisational setting. Then there is organisational awareness, the ability to read the currents of organisational life – build networks and navigate politics; and finally service orientation, the ability to recognise and meet customer needs.

One of the metaphors of organisations that I find most helpful is a metaphor for a social action theory, which sees organisations as a weave of commitments and understandings. Within this emotional intelligence frame, social awareness identifies the ability to read the currents of organisational life and I believe that in these two areas nurses have the lead over the rest of us.

My proposition arising from the second argument is that the experience nurses gain in the clinical setting provides them with the opportunity to develop emotional intelligence, specifically empathy and an organisational awareness.

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Rod Perkins has over thirty years experience in health. Having qualified as a dentist, he moved into planning and health administration in the Department of Health before gaining experience in the USA. After serving as CEO of the Thames Hospital Board he moved to Auckland in 1985, first as a consultant to the New Zealand Medical Association, then into top management in the Auckland Area Health Board.

In 1993 Rod began an academic career at the School of Medicine University of Auckland New Zealand. He is now a Senior Lecturer in Health Management and an Associate of the Centre for Health Services Research and Policy where he researches and teaches both undergraduates and postgraduates. He is also associated with EPIQ - an effective practice, informatics and quality research grouping.

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The third argument is about collectivism versus individualism and a systems approach to the delivery of health care, in other words, nurses are well positioned to deliver on the clinical governance agenda. Where does clinical governance agenda come from? It comes from the work of my PhD supervisor Pieter Degeling and his work on subcultures and health reform. Our view is that the agenda of the reform of clinical governance is going to move forward to the extent that an effective contemporary health care organisation will be effective to the extent to which its staff recognise interconnections between the clinical and resource dimensions of care. The interdisciplinary and hence the team based nature of service provision is very important; there has to be some balance between autonomy and accountability, in fact, transparent accountability is now the gold standard. Finally, we are in the production business and need to have some control systems. Quality control in every sense must be present in all health care activities.

That is the mantra, now I want to give you some findings from research, quite considerable in its breadth, which covers these issues. The research has used the same questionnaire in Australia, England, New Zealand, America, Malaysia and China. China is the only one that does not profile the way all the others do. We look at peoples' attitudes towards healthcare issues, strategies for addressing resource issues, autonomy issues, accountability issues, what is it that affects clinical practice, what causes variation in clinical practice, what are the dimensions between the clinical and resource dimensions of care and who should be involved in setting standards. We also look at what sort of management models are appropriate for improving the overall performance of clinical units; what sort of management style is appropriate; a subject's hospital's organisational goals and their affiliation with their hospital. The survey was initially done in New Zealand in 1999 involving 1800 subjects. We now have 3800 subjects.

What we found in the study is that occupational background best explains the differences between respondents rather than country of residence. The differences were around whether they were a nurse, a manager, or a doctor. Allied health professionals, called PAMs in England (professionals allied to health) are now included in this sub cultural pursuit.

There are Individualistic vs. collective conceptions of clinical work. The nurses believed that if there are problems in clinical delivery systems that can be traced back to the organisation. Doctors do not see institutional shortcomings as a cause of clinical practice variation. The nurses are pro systems and pro an integrated approaches to the delivery of care, whereas doctors believe in a medical ascendancy model of clinical management. The nurses are pro team, the doctors are not pro team – they do not see the team as essential. Nurses see that pathways, guidelines and evidence-based medicine increased their autonomy; doctors see it as "cook book" medicine decreasing their autonomy and the doctors reject the need to balance autonomy and accountability. Doctors are pro the use of self generated knowledge. Nurses reject that and are in favour of evidence-based health care.

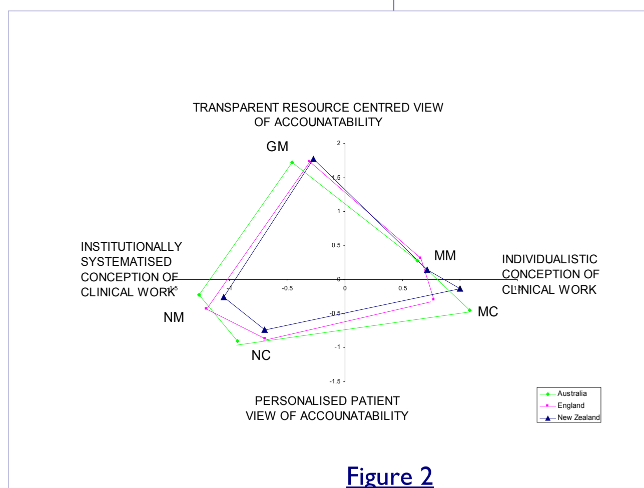

Figure 2

Let us now look at specifically at balancing clinical autonomy, transparent accountability and validating the interdisciplinary and hence the team based nature of service provision. When plotted on a graph, (Figure 2) what we see in an upper quadrant is a transparent and resource centred view and accountability means resources and being able to see it. Down at the bottom end of that continuum people see accountability in terms of patients. On the left we have a systems view where the organisation endorses the systems that are in use – pathways, guidelines, that sort of thing. On the right we have the individualistic view of clinical work. When we plot our data we see General Managers at the top, Medical Clinicians in the lower right, Nurse Clinicians in the lower left and Nurse Managers well over to the left. The plot is the same for Australia, England and New Zealand.

When we looked at a comparison between Auckland Hospital and the speciality hospitals (National Women's, Starship and Green Lane), the plot changed shape a little but the positioning between the various groups about accountability and teams versus individuals remained the same. Next, we looked to see if there was an inter-connection between resource and the clinical dimension of care. When looking at Auckland – Wellington data we found that Nurse Managers are on the 'pro work process control' side of the line and the clinicians are on the 'anti work process control' side of the line. There are people that say every clinical decision is a resource decision but just in terms of people's interest and willingness to have their work

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looked at, we see quite particular differences, in particular with nurse managers.

We have conducted another study with nursing, medical and pharmacy students going into their first day at university and we get the same sort of plot. This is even before they have attended their first lecture.

My third proposition is that Nurses are collectivists and support organisationally endorsed approaches to the delivery of clinical services- they are thus well equipped to meet the needs of clinical governance. From this follows my fourth argument, the orientation of nurses is both clinically and organisationally focussed.

Henry Mintzberg, who will be known to all of you who have studied management. Mintzberg and Sholem Glouberman have done a lot of work on the orientation of the different people involved in the health care family. Mintzberg interviewed a number of managers, nurses, doctors and members of boards of trustees. He found that they had quite different orientations. Some were orientated to their organisation of work, while some were oriented toward the external environment. Essentially, their thesis is that you have people with a primary interest in community, people with a primary interest in control, some with a primary interest in care and some with a primary interest in cure. They have recently published something, which you can find at www.healthandeverything.org/pubs/4C1.pdf where thinking organisationally, 'down' refers to direct links to the delivery of service; 'up' refers to the community who look to the health services for attention; 'in' refers to dependence on hospital hierarchy and interdependence; and 'out' refers to independence with respect to hospital hierarchy. (Figure 3)

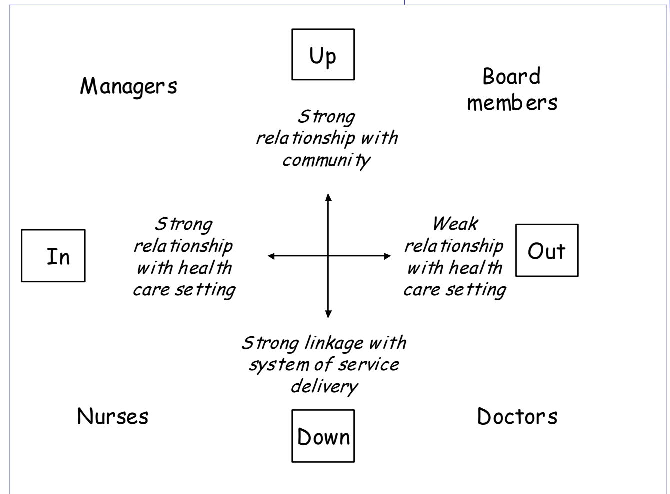


Figure 3

They found that Management were up and in, Boards up and out, Nurses down and in and Doctors down and out. Their message is nurses are the group with the orientation to both service delivery and health care setting.

Our fourth proposition is that health care organisations are going to become more instrumental (in respect to purpose) and focussed as we become more contractual and as information systems improve. We will have governments/ owners/shareholders wanting more "Organisation as machine" and nurses want to work in these sorts of organisations.

The fifth argument, which is the subject of further research, is that nurses can manage difficult conversations with other members of the health care team as a result of their knowledge of the industry, the roles and contributions of the key players in it and the attributes discussed in previous arguments

In summary, nurses are well suited to top management because they do not threaten key players in the health care setting, possess emotional intelligence- specifically empathy and organisational awareness, embrace key elements in the clinical governance agenda and are both clinically & organisationally oriented.

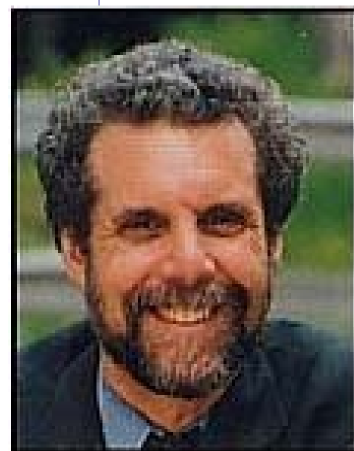
Some of the audience that kept Rod in 'conversation' for 20 minutes at the end of his presentation. For some, this is the most rewarding part of our seminars and will not be reported in Inform. Attend our next seminar for this added value sharing of knowledge.

Emotional intelligence 101

In our lead story Rod Perkins cites, with approval, emotional intelligence and the work of Daniel Goleman. EI has been around for a while but is a new concept to many of us. What is it all about?

EI has its roots in the concept of "social intelligence," first identified by E.L. Thorndike in 1920. Psychologists mainly group "intelligences" into three clusters: abstract intelligence (the ability to understand and manipulate with verbal and mathematic symbols), concrete intelligence (the ability to understand and manipulate with objects), and social intelligence (the ability to understand and relate to people). Thorndike defined social intelligence as "the ability to understand and manage men and women to act wisely in human relations." He includes inter- and intrapersonal intelligences in his theory of multiple intelligences. These two intelligences comprise social intelligence. He defines them as follows:

Interpersonal intelligence is the ability to understand other people: what motivates them, how they work and how to work cooperatively with them. Successful salespeople, politicians, teachers, clinicians, and religious leaders are all likely to be individuals with high degrees of interpersonal intelligence. Intrapersonal intelligence is a correlative ability, turned inward. It is a capacity to form an accurate, veridical model of oneself and to be able to use that model to operate effectively in life.


Daniel Goleman

Emotional intelligence, on the other hand, "is a type of social intelligence that involves the ability to monitor one's own and others' emotions, to discriminate among them, and to use the information to guide one's thinking and actions". EI involves abilities that may be categorized into five domains:

Self-awareness: Observing yourself and recognizing a feeling as it happens.

Managing emotions: Handling feelings so that they are appropriate; realizing what is behind a feeling; finding ways to handle fears and anxieties, anger, and sadness.

Motivating oneself: Channelling emotions in the service of a goal; emotional self control; delaying gratification and stifling impulses.

Empathy: Sensitivity to others' feelings and concerns and taking their perspective; appreciating the differences in how people feel about things.

Handling relationships: Managing emotions in others; social competence and social skills.

Researchers investigated dimensions of emotional intelligence (EI) by measuring related concepts, such as social skills, interpersonal competence, psychological maturity and emotional awareness, long before the term "emotional intelligence" came into use. Social scientists are just beginning to uncover the relationship of EI to other phenomenon, such as leadership, group performance, individual performance, interpersonal/social exchange, managing change, and conducting performance evaluations. According to Goleman, "Emotional intelligence, the skills that help people harmonize, should become increasingly valued as a workplace asset in the years to come."

Goleman has a new book on the market - Goleman D, McKee A., Boyatzis R.E (2002) *Primal Leadership: Realizing the Power of Emotional Intelligence: Transforming Leadership from Art to Science,* Harvard Business School.

Goleman and his co-authors present the case for cultivating emotional intelligence, which they say, underpins great leaders. They say that business leaders who maintain that emotions are best kept out of the work environment do so at their organisation's peril. Since the actions of the leader apparently account for up to 70% of employees' perception of the climate of their organisation, Goleman et al emphasize the importance of developing what they term "resonant leadership." Focussing on the four domains of emotional intelligence – self awareness, self management, social awareness, and relationship management they explore what contributes to and detracts from resonant leadership and how the development of these four EI competencies spawns different leadership styles.

The authors say that the best leaders maintain a style repertoire, switching easily between "visionary", "coaching", "affiliative", and "democratic". Such leaders make rare use of less effective "pace setting" and "commanding" styles. Their discussion on these methods is based on research in the workplace on the leadership styles of 3,870 executives. They use real life examples in a wide rang of work environments to illustrate their case and offer insights from developing the motivation to change and creating an improvement plan based on learning rather than performance outcomes, through to experimenting with new behaviours and nurturing supportive relationships that encourage change and growth. In a final section they take the personal process of developing resonant leadership and apply it to the entire organisational culture.

New Zealand Institute of Health Management
A Branch of the Australian College of Health Service Executives

For all inquiries re Branch activities or membership contact admin@nzihm.org.nz or (09) 445 0425 Phone/Fax

Up coming Seminars

August 19th

Breakfast Meeting @ Institute of Chartered Accountants
27 Ohinerau St, Remuera
7 a.m. for 7:30a.m.

The reporter's phone call: A well managed outcome or your worst nightmare

Sally Haysom, Managing Director, Professional Public Relation NZ.

Non Members Welcome

Cost
Members $20
Non Members $30
Breakfast supplied

October 16th

Attracting and retaining health workforce into the future

Graeme Ewing

Profile

Bruce Parkes, Inform editor and the last member of the current Branch committee to be profiled has enjoyed a serendipitous journey through life. So much so that he believes it is about time he settled down and got a real job. Bruce's paid 'Boys Own' adventure began at 15 when he joined the Navy and was transported to pristine spots, such as Antarctica and some other not so pristine, but differently interesting locations.

Moving on to the Police Bruce met "baddies" rioting inside prisons, "goodies" rioting outside rugby grounds, "music lovers" rioting in public squares, was involved in a number of high profile homicide investigations and 'enjoyed' regular night time call outs as an Armed Offenders Squad member.

After a period as a consultant operational auditor , Bruce moved into Health and suddenly realised where true emergency service and crisis management was to be found. He has a role, funded by the Ministry of Health, to facilitate emergency planning by healthcare providers in the territory from Ruapehu to North Cape. That, and an associated role as Relationship Manager for the pilot Healthline telephone nurse advice service, regularly takes him into hospitals and other healthcare facilities in almost all parts of the country. He has welcomed an opportunity to witness at first hand the different challenges faced by all health service providers and the commitment, above and beyond the call of duty, of staff at all levels in both those organisations and the much maligned funding and policy sector.

A mature student who forgot to stop because he kept finding interesting papers to read, Bruce has a Masters in Health Management from Massey and is a CIA (Certified Internal Auditor). Abandoning formal study through the constraints of 1 semester papers on extra mural study, Bruce finds the challenge of background reading in the preparation of Inform provides a satisfactory alternative.

Now released from the demands of involvement with junior sport— our children do eventually grow up, Bruce's main community involvement is as the honorary secretary/treasurer of a small philanthropic community trust in Mt Albert.

Minter Ellison closes Health Practice

MinterEllisonRuddWatts have announced the closure of their Health Practice and with that their sponsorship of our Branch seminar programme. Those many members who have enjoyed MinterEllison hospitality and the informed presentations by Wendy Brandon and her team will appreciate the huge contribution they have made to our activities. We thank them for their contribution and look forward to renewing acquaintances some time in the future.

As a result of this change we have decided to forego our July seminar as it was to be closely followed by our Institute's annual conference.

MinterEllisonRuddWatts
LAWYERS