

Doctors as health managers: an oxymoron, or a good idea?

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Abstract

Purpose – The purpose of this paper is to review the current literature and summarises the benefits and limitations of having doctors in health management roles in today's complex health environment.

Design/methodology/approach – This paper reviews the current literature on this topic.

Findings – Hospitals have evolved from being professional bureaucracies to being managed professional business with clinical directorates in place that are medically led.

Research limitations/implications – Limitations include the difficulty doctors have balancing clinical duties and management, restricted profession-specific view and the lack of management competencies and/or training.

Practical implications – The benefits of having doctors in health management include bottom-up leadership, specialised knowledge of the profession, expert knowledge of clinical care, greater political influence, effective change champions to have on-side, frontline leadership and management, improved communication between doctors and senior management, advocacy for patient safety and quality, greater credibility with public and peers and the perception that doctors have more power and influence compared to other health professionals can be leveraged.

Originality/value – Overall, there are more benefits than there are limitations to having doctors in health management but there is a need for more management training for doctors.

Keywords Health care, Health management, Health managers, Clinical directorates, Hospital management

Paper type Research paper

Introduction

Hospitals have evolved from being straightforward centres of advice and healing based in temples in ancient Greece (Risse, 1990) into complex organisations (Baker, 2001; Shoemaker, 2010). Hospitals in Australia consume 3.4 per cent of the national gross domestic product, totalling \$38.5 billion (AIHW, 2010a). Within these hospitals are different types of health professionals, and medical practitioners or “doctors” are a major health professional group (AIHW, 2010b). These doctors who work in hospitals are either salaried employees or work as independent private contractors (Hoff, 2003). Most doctors who work in hospitals work in a full-time clinical role and practise medicine in a medical specialty. There are 850,000 people working in the health workforce (AHMAC, 2008), with about 10 per cent of this number being doctors, who are increasingly moving into hospital management (Doolin, 2001). Some are involved in management as part-time clinician managers (Braithwaite, 2004) and some work as full-time medical hospital managers (Dwyer, 2010b). Doctors are an essential component of the clinical care team, and have higher influence and power compared to other staff members (Degeling *et al.*, 1998, 2003). The engagement of doctors in health



care delivery is increasingly seen as a key issue (Bohmer, 2013; Lin *et al.*, 2014). This paper reviews the current literature and summarises the benefits and limitations of having doctors in health management roles in today's complex health environment.

Models of doctors in health management

Professional bureaucracies

From the 1960s to the late 1980s, professional organisations such as hospitals were managed by the clinicians, the elite professionals who had the power and influence to control the organisation (Dickinson *et al.*, 2013; Greenwood *et al.*, 1990). Such organisations were known as “professional bureaucracies” (Mintzberg, 1979, p. 348) and external non-professional influences on these organisations were limited. Moreover, hospitals at that time were decentralised in their management structure, and so collective decision making by peer groups of professionals was the norm, with managers and leaders coming from within the profession itself (Dickinson and Ham, 2008). Therefore, compared to traditional management structures, these organisations were managed from the bottom-up rather than top-down, and the management structure tended to be. These organisations were less likely to change, and roles within them were more specialised and less formal (Friedson, 1986; Mintzberg, 1980).

Doctors form one of the main professional groups of clinicians operating in hospitals that contributed to the professional bureaucracy culture (Dickinson and Ham, 2008; Friedson, 1986). Doctors (like some other clinicians), because of their training and experience, have specialised knowledge that can be withheld from non-medical managers and third parties. This exclusivity was one of the ways that doctors were able to derive power and influence, and management needed to be able to work within this framework. Indeed, doctors and non-clinician managers were sometimes expected to be in conflict (Dickinson and Ham, 2008). It was the doctors who had market forces and political influence on their side. As such, doctors had power to block organisational strategy and processes, if they disagreed with management. In brief, professional bureaucracy was dominant in hospitals.

Managed professional business

However, because of market forces, increasing competition and corporate governance pressures, hospitals have shifted from being professional bureaucracies where clinicians manage other clinicians (Baker and Denis, 2011). For example, some hospitals became managed by non-clinician managers trained in management who were not promoted from within the clinical profession itself. This non-clinician management model is known as the “managed professional business” model (Cooper *et al.*, 1996, p. 631). This model still allows for a professional base, but there is an additional layer of expert managers over the professionals, bringing additional corporate values and strategy.

However, this model in hospitals has been criticised for removing the dynamic and flexible nature of the traditional professional-run hospital by being too top-down in its approach (Degeling *et al.*, 2003). Indeed, the history of being managed by one of their own has led to clinicians, including doctors, retaining some of the culture that comes with professional bureaucracies (Dickinson and Ham, 2008). Hospitals are one of the few organisations where distinct sub-cultures continue to co-exist in silos, separate from one another with poor linkages between them (Bate, 2000). For example, it is still difficult to impose some changes on doctors even though many issues facing hospitals require their involvement (Guthrie, 1999). So, despite these attempts to replace

professional bureaucracies within hospitals with a managed professional business model across most western nations, many of the elements of a professional bureaucracy culture remain (Bate, 2000; Kitchener, 1999).

Clinical directorates

Some doctors retain a management role because of the existence of such microsystems, defined as the smallest replicable unit within an organisation, each having its own human, financial and technological resources (Denis, 2013; Quinn, 1992). Indeed, the best performing microsystems tend to have two or three leaders sharing management responsibilities instead of one (Batalden *et al.*, 2003). This shared management team is also known as a clinical directorate. Clinical directors are senior doctors who are heads or directors of a clinical unit that they manage while maintaining clinical practice on a part-time basis. These clinical director roles mix clinical functions and management responsibilities together (BAMM, 2004; Kuntz and Scholtes, 2013). These clinical directorates have led to the development of the medical clinician manager as a distinct role in hospitals (McKee *et al.*, 1999).

These clinical directors are supported by a management team that includes a nursing manager and a business manager, as illustrated in Figure 1. Clinical directorates are the main clinical management structure used by acute services in hospitals in western countries (Braithwaite *et al.*, 2005b). Furthermore, the clinical director can also improve the communication channels between senior management and the doctors on the ground (Braithwaite *et al.*, 2005a).

However, clinical directors in middle management can be effective only if their actions and positions are legitimised by senior management and the wider organisation (Degeling *et al.*, 2003). Furthermore, doctors who are clinical directors are often the most disenchanted of all health managers in the hospital system (Davies *et al.*, 2003). Doctors who work in medical management such as clinical directors sit on the fence between the professional clinical world and the world of politics and management (Marnoch *et al.*, 2000).

Specialist hospital management

Besides clinical directors who work in middle management, there are other more senior medical management roles for doctors within hospitals (Empey *et al.*, 2002). Unlike clinical directors who are usually part-time, doctors who work full-time in senior hospital management work either as the chief medical officer (a role specifically for

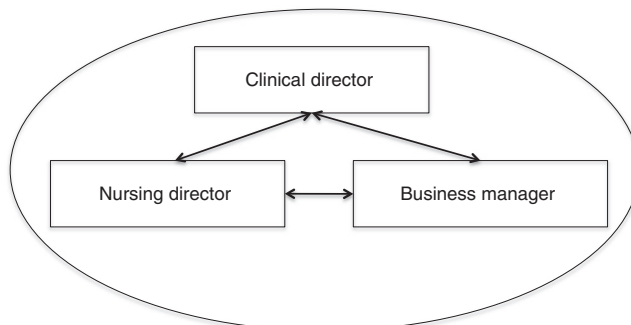


Figure 1.
Clinical directorate
structure

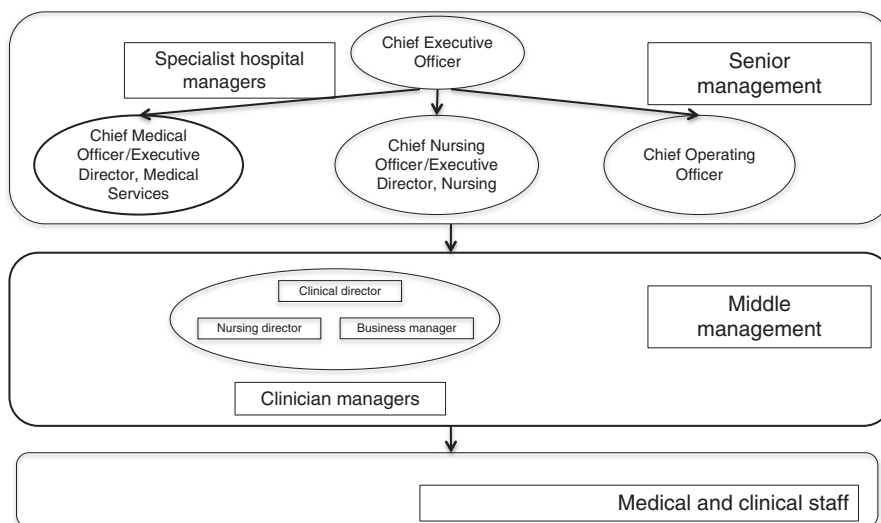
Source: Developed for this paper

doctors), or as chief executive officer of a hospital (Edmonstone, 2009). The relationship between doctors in middle and senior management roles is outlined in Figure 2.

Doctors who work in senior hospital management roles that are doctor-specific have positions such as chief medical officer, executive director of medical services, director of medical services, director of clinical services or medical director (Dwyer, 2010b). They report directly to the chief executive officer of the hospital. The chief executive officer is the highest executive role in a hospital. Queensland, Western Australia and the UK have moved towards having doctor chief executives in their major public hospitals (Dickinson and Ham, 2008; Ham *et al.*, 2010).

Indeed, these doctors in senior management are seen to have greater credibility, deeper knowledge of how health care works and a less restricted ability to speak out (Simpson and Smith, 1997). Doctors who work in management stress the importance of maintaining vocational autonomy and professional culture over the needs of the organisation, in order to optimise patient care (Degeling *et al.*, 1999, 2001). For example, there are differences between medical and nursing managers, with medical managers being seen as having more power and authority to support or block initiatives due to the nature of their roles compared with nursing managers' (Degeling *et al.*, 1998, 2003). However, doctors in these full-time management roles often face an identity problem, with their clinical colleagues not seeing medical management as a medical specialty (Fitzgerald *et al.*, 2006).

Thus, there has been a move to formalise medical management into a distinct accredited medical specialty in some jurisdictions. For example, accredited medical specialists in full-time hospital management roles are known as specialist medical administrators in Australia (AMC, 2011), medical managers in the UK (BAMM, 2004) and physician executives in the USA (ACPE, 2011). A specialist medical administrator is a registered medical practitioner with a medical degree and dual qualifications in medicine and management, who has undertaken a predominant management role in health care (Dwyer, 2010a). Senior hospital management roles for doctors are filled by



Source: Developed for this paper

Figure 2.
Medical managers in
senior and middle
management

doctors who have decided to specialise in medical management as a career (Montgomery, 1990). Doctors who move into these full-time medical management as a specialty do not see such a move as replacing their clinical role, but rather enhancing it (Hoff, 1998, 2001).

Nevertheless, management competency training received by doctors in senior management is variable and inconsistent (Ham *et al.*, 2010) and there is a need for more of it (Medina-Walpole *et al.*, 2004). Despite increased efforts to provide additional management training to doctors (Mahmood and Chisnell, 1993), such training lacks coordination and relevance (Walker and Morgan, 1996). Only some doctors in hospital management roles will have undergone postgraduate management training (Vera and Hucke, 2009). Some of these doctors undergo management training after they are in their management roles and there are challenges in the development of management training for doctors (Guthrie, 1999).

Discussion

Distilled from the existing literature, the benefits of having doctors in health management roles can be summarised in Table I and the limitations in Table II. In brief, doctors are able to provide the benefits of bottom-up leadership (Dickinson and Ham, 2008), specialised knowledge of the medical profession and clinical care (Friedson, 1986), and greater political influence (Dickinson and Ham, 2008). Doctors can also be effective change champions in leadership positions, and provide frontline leadership and management (Guthrie, 1999). Doctors in management roles can lead to improved communication between doctors and senior management (Braithwaite *et al.*, 2005a), and

Benefits

1. Bottom-up leadership
2. Specialised knowledge of profession
3. Expert knowledge of clinical care
4. Greater political influence
5. Effective change champions to have on-side
6. Frontline leadership and management
7. Improved communication between doctors and senior management
8. Advocate for patient safety and quality
9. Greater credibility with public and peers
10. Perceived to have more power and influence compared to other health professionals

Table I.

Benefits of having doctors in health management roles

Source: Developed for this paper based on Batalden *et al.* (2003), Braithwaite *et al.* (2005b), Degeling *et al.* (1998, 1999, 2001, 2003), Dickinson and Ham (2008), Friedson (1986), Guthrie (1999) and Simpson and Smith (1997)

Limitations

1. Difficulty balancing clinical world and management/identity crisis
2. Restricted profession-specific view
3. Lack of management competencies and/or training

Table II.

Limitations of having doctors in health management roles

Source: Developed for this paper based on Fitzgerald *et al.* (2006), Ham *et al.* (2010), Marnoch *et al.* (2000), and Vera and Hucke (2009)

are strong advocates for patient safety and quality (Degeling *et al.*, 1999, 2001). Doctors also have greater credibility with public and peers (Simpson and Smith, 1997), and are perceived to have more power and influence compared to other health professionals (Degeling *et al.*, 1998, 2003).

On the other hand, there are also limitations to having doctors in health management, as shown in Table II. Doctors in management roles, especially those in clinician-manager roles such as clinical directors, may have difficulty balancing their clinical responsibilities with their management ones, which can lead to an identity crisis and/or a more restricted profession-specific viewpoint rather than a holistic one (Fitzgerald *et al.*, 2006; Marnoch *et al.*, 2000). One of the barriers for doctors moving into management is the perception that they are moving to the “dark side” (Loh, 2013). Doctors may also not have the requisite training and/or have the require management competencies for a health management role (Ham *et al.*, 2010; Vera and Hucke, 2009). There is a need for doctors to be better equipped with management skills based on a competency framework (Loh, 2014b; Wilkie and Spurgeon, 2013). Part of this is the need for doctors to not only learn about leadership, but also about followership (Loh, 2014a).

Conclusion

In summary, this paper has shown that management in hospitals has come full circle, with a move to once again have doctors lead hospitals in senior management positions (Ham, 2008). The attempt to replace professional bureaucracies in hospitals with a managed professional business model has been unsuccessful and a hybrid model is in place (Bate, 2000). There more benefits than there are limitations to having doctors in health management. There is a need for more management training for doctors so that they can be competent health managers.

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