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CONTENTS

'The cover depicts the two aspects of this issue and that it is the first 'special issue produced. The two word clouds describe the range of topics discussed and the complexity of issues faced by managers and leaders in the context of a modern healthcare system'.

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The ethics of managing health services: Why does it matter?

A number of national and international health Inquires over the last 15 years has drawn attention to the decision-making processes of health managers. [1-6] Healthcare managers are coming under increasing scrutiny for their decisions not only by patients, but also by the community at large. 'Health managers frequently face ethical tensions and conflicting obligations when making decisions and managing health departments.' [7, p.358] The public has every right to question the quality and ethics of managerial decisions, particularly where it involves the expenditure of public monies or patient outcomes. [8] This public scrutiny requires managers to not only be increasingly aware of their roles and responsibilities, but also in how health managers are developed and educated. Just as we can stand in front of the same piece of artwork in a gallery and it evokes different feelings and emotions for those viewing it, so is the process of managerial decision-making. A number of health managers can be faced with the same issue and due to looking through different ethical lenses come up with differing outcomes. Understanding the ethical approaches of health managers is critical to a broader understanding of how services operate as well as the quality of the outcomes of those decisions.

The healthcare manager of the future will face an increasing number of challenges related to the ongoing global trend of increasing life expectancy and the reduction in available resources which can bring a great challenge in term of managing healthcare facilities efficiently and effectively. Healthcare managers will face increased pressures to balance clinical and financial imperatives clinical and financial pressures and '…it does not matter what level of management is under consideration - top, middle, or lower; managers at all levels, and in all functions, face situations wherein ethical considerations play a major role.' [9, p.141]

Ethical behaviours, decision-making and leadership are becoming increasingly important in the healthcare industry due to the switch of strategic focus from being traditionally 'service oriented' to being more 'profit oriented.' [10, p.51] Due to this switch, and with the increasing pressure to satisfy the financial business model, the healthcare industry has been undergoing a process of restructuring that has not been immune to unethical practices and public attention.

[10] Another element to add to the risk of unethical behaviour in the healthcare industry is the fact that it has been service based for hundreds of years, and therefore it is rich in precedents and references for law, medicine and ethics in clinical medicine, but poor in references for ethics in healthcare management processes. [11]

In this transitional period there are very high risks in a complex industry like health. While patient safety is paramount, other drivers – such as financial sustainability, resource allocation, constant restructuring and political pressures could have a strong influence on managerial decision-making. There is a danger that questionable individual decisions could be made that represent new opportunity for conflict between the individual values and organisational values. [12] Insidiously, the opportunity for unethical individual values can create an unethical organisational culture, and eventually lead to unethical industry practices. Health managers will increasingly be caught in the interplay between health policy, politics and practice and to guard against this, will require strong ethical frameworks to ground their decision-making processes.

One important message for all healthcare managers is that despite the complexity of the industry and the necessity for immediate decisions and results it is always important to remember that we all are responsible for the future of this industry and the safety of our patients through the decision that we make. We owe it to the patient and the health service to consider our own ethical approaches to decision-making as well as develop a deeper appreciation of the ethical frameworks of others. As health managers are called increasingly to account for their decisions, exploring concepts around ethical decision-making and ethical decision-making frameworks is critical to the development of tomorrow's health care leader.

Professor Gary E Day and Dr Gian Luca Casali
Co-editors – Special Issue

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Ethics of Managing and Leading Health

This special issue has been edited by Professor Gary Day from Griffith University and Dr Luca Casali from the Queensland University of Technology and comprises of nine national and international papers dealing with aspects of the ethics of leading and managing health services.

The special issue commences with an empirical paper by Casali and Day on a taxonomic approach to understanding managerial ethical decision-making approaches of clinically and non-clinically trained healthcare managers in Australia. The paper identifies five managerial ethical decision-making profiles amongst health managers and suggests how an understanding of these profiles might be used, from an individual manager or organisational perspective. Of note, the paper identified that there was no statistical difference between clinically and non-clinically trained managers when it came to the five ethical profiles.

The next paper provides an interesting insight into the ethics of leading and managing health services from an international perspective. Armit and Oldham provide a commentary on what can happen when leaders and managers focus on finances at the expense of the health and wellbeing of staff and patients. The paper dissects the lessons learned from the NHS Mid Staffordshire Trust and the ethical responsibilities expected of health managers. The authors point to the requirements of the players in the system (professional bodies, regulators and politicians) and their impact on creating an ethical culture and climate for improved patient care and safety.

The third paper in this special issue explores the ethical climate of an organisation and how it can be described as the lens by which employees determine what comprises 'correct' behaviour within that organisation. Dark and Rix argue that an outcome of the organisation's culture is a culmination of the organisation's history, its structure and systems, the external environment and the individuals working within it. Through a focused literature review, this paper finds that empirical studies involving the Ethical Climate Questionnaire in not-for-profit organisations are limited. Recent regulatory reform in the not-for-profit sector, increased community expectations, and the fact that services are often provided to vulnerable populations suggest a focus on the systems that support and demonstrate ethical decision-making is long overdue.

The next commentary by Day and Casali explores what has been learnt from recent Health Inquiries and what might result if the mistakes of the past happen again. The paper highlights a number of themes that are common across the Inquiries and poses questions as to why the likes of these failures are likely to re-occur as well as possible learnings for the management of health services to address a number of these common themes.

Jones and Milligan's paper argues that decision-making in healthcare demands consideration of not only the clinical, operational or financial aspects of care but increasingly complex ethical issues. It is vital that staff be provided with a 'safe space' to speak of the ethical challenges they are encountering if we are to take staff safety as seriously as we take patient safety. The paper explores the who, what and why questions embedded in ethical decision-making. Drawing on Roger L Martin's concept of heroic leadership, stakeholder roles and moral orientations, the paper outlines the work of a Clinical Ethics Service.

The sixth paper by Dinesh points to health leaders needing to think and behave differently when implementing reform. The commentary argues that it is incumbent on health professionals with technical skills, experience and expertise to remain cognisant of the changing landscape, culture and community, understand patient and community expectations and lead development of a new vision, strategy and clinical systems and processes.

The paper by Sebastian is a fine follow up to the sixth paper as the commentary provides an insider's view of two national conversations leading to an agreed and approved health leadership framework for Australia. The perspective highlights the national aspirations for developing leadership for a people-focused health system that is equitable, effective, ethical and sustainable. While the development of a national health leadership framework has faltered with the transfer of custodianship, the paper highlights that the framework has the potential to raise the bar of health leadership in Australia.

The next paper by Harden and Fulop explores relational leadership and how this approach can make a difference to how decision-making is practised. The research concluded that while relationally oriented discursive practices can be a part of professional sensemaking, they are not always developed and multi-ontology sensemaking can be hard to achieve. Single ontology sensemaking, if left unchallenged by health professionals, has consequences for complex decision-making. Skilful relating can enable multi-ontology sensemaking, which can change the course of decision-making.

The final paper looks at the ethics of decision-making in health research. The authors describe a number of cases where research has been blocked at various levels by Australian health organisations, managers and clinicians for reasons of corporate and individual self-interest, rather than ethical or resource-related concerns. Murgatroyd, Karimi, Robinson and Rada argue that ethical aspects of research gatekeeping, including societal and individual aspects, need to be considered together with possible motivations. The authors ask whether patterned, covert and unauthorised misuse of gatekeeping powers is an under-considered problem affecting evidence-based practice and the right to research participation and call for more research into this phenomenon.

A Taxonomic Approach to Understanding Managerial Ethical Decision-Making Approaches of Clinically and Non-Clinically Trained Healthcare Managers in Australia

G L Casali and G E Day

Abstract

Objective: To understand differences in the managerial ethical decision-making styles of Australian healthcare managers through the exploratory use of the Managerial Ethical Profiles (MEP) Scale.

Background: Healthcare managers (doctors, nurses, allied health practitioners and non-clinically trained professionals) are faced with a raft of variables when making decisions within the workplace. In the absence of clear protocols and policies healthcare managers rely on a range of personal experiences, personal ethical philosophies, personal factors and organisational factors to arrive at a decision. Understanding the dominant approaches to managerial ethical decision-making, particularly for clinically trained healthcare managers, is a fundamental step in both increasing awareness of the importance of how managers make decisions, but also as a basis for ongoing development of healthcare managers.

Design: Cross-sectional.

Methods: The study adopts a taxonomic approach that simultaneously considers multiple ethical factors that potentially influence managerial ethical decision-making. These factors are used as inputs into cluster analysis to identify distinct patterns of influence on managerial ethical decision-making.

Results: Data analysis from the participants (n=441) showed a similar spread of the five managerial ethical profiles (Knights, Guardian Angels, Duty Followers, Defenders and Chameleons) across clinically trained and non-clinically trained healthcare managers. There was no substantial statistical difference between the two manager types (clinical and non-clinical) across the five profiles.

Conclusion: This paper demonstrated that managers that came from clinical backgrounds have similar ethical decision-making profiles to non-clinically trained managers. This is an important finding in terms of manager development and how organisations understand the various approaches of managerial decision-making across the different ethical profiles.

Abbreviations: ACHSM– Australian College of Health Service Management; CFA – Confirmatory Factor Analysis; MEP – Managerial Ethical Profile.

Key words: clinician managers; cross-sectional; decision-making; ethics; hospitals; non-clinician managers.

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Introduction

Healthcare managers are increasingly being called on to justify their decisions, particularly when there are negative or unexpected outcomes. With increasing scrutiny of the outcomes of decisions made in health services, more needs to be done to understand the processes managers employ to arrive at a given decision. This paper seeks to understand whether identifying and understanding potential patterns of influence can provide a foundation for a new managerial ethical decision-making taxonomy for healthcare managers.

Background

The degree of interdependencies among administrative and clinical issues within healthcare organisations has become less obvious and more tangled. [1] Therefore, healthcare managers have to maximise the scarce resources at their disposal and at the same time ensure that ethical practices and processes have been embedded and respected at all times. This situation has been increasingly highlighted with the trend to involve more non-clinician decision-makers in clinical issues. [1] As a result of this trend it can be argued that clinician and non-clinician managers tend to use different lenses to look at a situation, which can result in each group taking different approaches based on their professional knowledge and experience. What brings another level of complexity is the fact that professional affiliation is not the only possible lens that managers might use; individual, ethical, organisational and external factors can also provide different lenses to investigate and understand any phenomenon. [2] Therefore, each individual healthcare manager might see and assess what could seem at first glance to be a similar problem differently from another manager. Consequently, despite both healthcare managers dealing with a similar issue they might come to very different solutions that seem appropriate for each individual manager at the time. Those factors (lenses) can vary in nature and in the degree of influence that they have on the decision-maker.

The healthcare system in general as well as individual managers (doctors, nurses and non-clinicians) can benefit from a categorisation or taxonomy system to highlight the conscious and unconscious decision-making preferences that underpin the day-to-day processes that managers go through to arrive at a given outcome.

The study

Aim

The main aim of this paper is to understand differences in the managerial ethical decision-making styles of Australian healthcare managers through the use of the Managerial Ethical Profiles (MEP) Scale. The MEP Scale was specifically developed for this study to measure the ethical decision-making preferences of health managers.

Design

This cross-sectional study evaluated the potential influence of eight ethical factors in the decision-making of different healthcare managers and, based on the different patterns of influence, developed a number of clusters (profiles). The relationships of the clusters, comparing the different type of managers (clinically trained and non-clinically trained), were evaluated. For the purposes of the study, clinically trained managers were considered to be those that had a clinical background (medicine, nursing, allied health) before

Table 1: Participants' information (N=441)

VARIABLE NAME	FREQUENCY	PERCENTAGE	VARIABLE NAME	FREQUENCY	PERCENTAGE
GENDER			**ROLE**		
Female	244	55.3	Corporate Governance	66	15
Male	197	44.7	Supervisor	58	13.2
AGE			Manager	193	42.8
Less than 30	20	4.5	Senior Manager	71	16.1
30-39 years	56	12.7	Consultant	53	12
40-49 years	165	37.4	**YEARS OF EXPERIENCE**		
50-59 years	175	39.7	Less than 1	61	13.8
60 and over	25	5.7	Between 1-3	119	27
EDUCATION			Between 4-6	97	22
Undergraduate	91	20.6	Between 7-10	76	17.2
Postgraduate	350	79.4	More than 10 years	88	20
HOSPITAL OWNERSHIP			**BACKGROUND**		
Public	274	62.1	Clinically trained	173	39
Private	127	28.3	Non-clinically trained	268	61
Not For Profit	42	9.5			

becoming managers. Non-clinically trained managers were those that came from a 'pure' management background (management, human resources, finance, business) or other. In this study clinically trained managers were analysed as a whole rather than as sub groups as respondents were only asked to indicate that they had a clinical background rather than nominate a clinical profession.

Sample/participants

As seen in Table 1, a sample of 441 usable questionnaires was collected from one healthcare association's total membership of 2473, providing a 17% response rate.

Data collection

Research subjects were recruited via an introductory email sent to them from an Australian healthcare managers' association (Australasian College of Health Service Management – ACHSM). The ACHSM (and its predecessors) is a not-for-profit association that has been in existence for over 70 years and provides opportunities for networking, professional development and advocacy for health leaders and managers. The ACHSM was used as a vehicle for the data collection as it represented the peak professional body specifically for health service managers in Australasia. This presented the opportunity to obtain data from managers across a range of healthcare settings (public, private and not-for-profit).

Research instrument

This study used the MEP Scale designed to capture managerial ethical preferences. [3] The MEP Scale measures the degree of influence that different ethical factors have on managerial decision-making. The ethical factors are represented by 24 items that have been subdivided into four main groups of six items each in order to measure the following Schools of Moral Philosophy: Ethical Egoism, Utilitarianism, Virtue Ethics and Deontology (See appendix 1). The six items used for each of the four categories have been further divided into two subsets based on the major internal differences within each ethical framework. [3] A description of the eight ethical subscales is as follows. Ethical Egoism has two main dimensions: Economic Egoism (SS1), which represents managerial self-interest, particularly in terms of the role that economic outcomes such as profit and cost reduction play in the managerial decision-making process. The second is Reputational Egoism (SS2), which refers to managerial self-interest pursued not in terms of economic outcomes but by identifying one's organisation as an extension of one's own interests. Therefore, the manager would act to protect the organisation's reputation – possibly

even at the expense of profits. Utilitarianism's first dimension is Act Utilitarianism (SS3) and encompasses the idea that in order to create the greatest overall good it is fundamental to evaluate whether the consequences of each proposed action would create the greatest benefit for the greatest number of stakeholders. Conversely, Rule Utilitarianism (SS4) expresses the same interest in the greater good, but instead of focusing on each separate action it proposes to establish and follow those rules that benefit the majority. Virtue Ethics has two dimensions, the first being Self-Virtue (SS5), which measures the degree of importance attached to individual moral character as a determinant of good decision-making. The second is Others Virtue (SS6), a particular framework of virtue ethics which concerns living well with others, promoting social wellbeing and includes what is referred to as 'care' ethics. The last school of moral philosophy, Deontology, has Act Deontology (SS7) as its first dimension, which measures the degree of importance attached to doing the right thing or fulfilling one's duty in a particular situation. Finally, the second dimension of Deontology is Rule Deontology (SS8), which focuses on fulfilling universal duties, such as the Golden Rule, or acting according to universal principles (e.g. justice, not harming others, doing good and respecting autonomy) in all situations. Table 2 outlines these eight ethical subscales that were used in order to profile healthcare managers in this study.

Ethical consideration

This research was approved by the QUT Human Research Ethics Committee (Ref. 0700000112) in line with the approving university's policies and procedures. The ACHSM board approved the study for distribution amongst its members.

Data analysis

The survey data were analysed in several ways by using SPSS version 21. Firstly 24 items reflecting the ethical factors were computed based on the eight ethical subscale structures as required in the MEP Scale. [3] Following this a two-step cluster analysis was performed. As this is an exploratory study for this industry, and there is no a priori number of clusters or a well validated typology, expected different cluster solutions were tested both empirically and theoretically. The five-clusters structure was chosen due to its strong internal consistency and external significant differences. Finally, a multinomial regression analysis was used to measure the possible relationship between the five clusters and manager types (clinically trained and non-clinically trained).

Figure 1: Taxonomy development process

Phase 1 Clusters Formation

Factors
- Ethical Egoism
- Ethical Reputation
- Rule Utilitarian
- Act Utilitarian
- Virtue Ethics (Self)
- Care Ethics
- Act Deontology
- Rule Deontology

Ethical Factors 24 Items

Clusters
- Cluster 1
- Cluster 2
- Cluster 3
- Cluster 4
- Cluster 5

Phase 2 Cluster Validation

Internal Validation
- Differences between clusters — MANOVA ANOVA SCHEFFE
- Degree of agreement within clusters — Within group Interrater Reliability

Validated Clusters
- Knight
- Chameleon
- Defender
- Guardian Angel
- Duty Follower

Sample (N = 441) Health Care Managers

Validity and reliability

Firstly, a Confirmatory Factor Analysis (CFA) was used with the sample comprising 441 managers to validate and create the computed results of the eight ethical factors from the MEP survey results.

Secondly, the computed results of those eight ethical factors were used to create a number of clusters based on the degree of influence that they had on the respondents' decision-making processes. A two-step cluster method was used to validate the clusters that emerged from the study due to the fact that this method handles large datasets well.

Thirdly, this study used two main tools to validate the five clusters: the first was to provide evidence of high external heterogeneity and the second; high internal homogeneity. [4] Internal homogeneity shows the degree of agreement between each manager within each cluster in relation to the degree of influence that the eight factors had on their decision-making processes. The within-group interrater reliability test was used for this purpose. [5] Figure 1 illustrates the process undertaken to develop and validate the cluster taxonomy. After the clusters were validated a number of regressions were also run in order to further justify the need for and contribution of the taxonomy.

Results

The study results can be divided into: (i) CFA of the ethical factors from the MEP, (ii) the results of the cluster analysis, (iii) cluster validation, and (iv) regression analysis.

Results: Confirmatory Fact or Analysis

CFA was used on the 24 items from the MEP using AMOS 7.0 SEM software. The results of the CFA are as follows: CFI= 0.933, RMSEA= 0.057 and SRMR= 0.00467. The results of the CFA suggest that the data used for this study provide a good model fit for the eight ethical subscales of the MEP, and therefore the computed results of the eight subscales were used as factors for the cluster analysis.

Results: Two-step cluster analysis

Results of the two-step cluster analysis performed on five desired clusters are shown in Table 2.

Internal validity: Manova, Anova, Scheffe and within-group interrater reliability

The first part of the internal validity analysis for the five clusters is to validate the significance of the degree of external heterogeneity between them. Manova showed that the five clusters were significantly different (F= 38.231, p < 0.001). Variations in dimensions of the ethical subscales among the five clusters were gleaned from ANOVA, as summarised in Table 2. Scheffe tests also highlighted the distinguishing

Table 2: Standardised means of the five MEPs: results of the two–step cluster, ANOVA, and Scheffe

| ETHICAL SUB–SCALES | MANAGERIAL ETHICAL PROFILES | | | | | SCHEFFE RESULTS SIGNIFICANT DIFFERENCES BETWEEN CLUSTERS | F |
	CLUSTER 1 (KNIGHT) 121 (28%)	CLUSTER 2 (GUARDIAN ANGEL) 60 (13%)	CLUSTER 3 (DUTY FOLLOWER) 74 (17%)	CLUSTER 4 (DEFENDER) 118 (26%)	CLUSTER 5 (CHAMELEON) 68 (16%)		
SS1 (items 1,2 & 4)	4.2	3.2	3	3.7	3.2	1 &2; 1&4; 1&5; 3&2; 3&4; 4&2; 4&5	52.085*
SS2 (items 3 & 6)	4.8	3.8	4.4	4.4	3.7	1&2; 1&3; 1&4; 1&5; 3&2; 3&5; 4&2; 4&5	71.230*
SS3 (items 8 & 9)	4.6	4.6	4.3	4.0	3.5	1&3; 1&4; 1&5; 2&3; 2&4; 2&5; 3&4; 3&5; 4&5	70.183*
SS4 (items 11 & 12)	5.0	4.8	4.9	4.8	3.2	1&5; 2&5; 3&5; 4&5	66.533*
SS5 (items 13 & 14)	5.0	3.9	3.9	4.1	3.7	1&3; 1&4; 1&5; 2&3; 2&4; 3&5; 4&3; 4&5	128.776*
SS6 (items 15,16, 17 & 18)	4.7	4.5	4.5	4.0	3.7	1&3; 1&4; 1&5; 2&3; 2&4; 2&5; 3&4; 3&5; 4&5	126.694*
SS7 (items 19,20 & 21)	4.5	4.4	4.4	3.7	3.5	1&4; 1&5; 2&4; 2&5; 3&4; 3&5	73.211*
SS8 (items 22,23 & 24)	4.9	4.8	4.8	4.3	3.9	1&4; 1&5; 2&4; 2&5; 3&4; 3&5; 4&5	148.684*

** SS1 Economic Egoism, SS2 Reputational Egoism, SS3 Act Utilitarian, SS4 Rule Utilitarian, SS5 Virtue of Self, SS6 Virtue of Other, SS7 Act Deontology, and SS8 Rule Deontology *p<0.001

qualities of the five managerial ethical profiles. In reviewing the profiles of the five clusters (Table 2) the reader should know that because the number and content of clusters were inseparable from the classification criteria used, the results of ANOVA are presented only to illustrate where the greatest differences exist among the clusters. The second part of the validation is to measure the degree of agreement (internal homogeneity) inside each cluster. The results of the application of the degree of interrater agreement within each of the five clusters are as follows: Cluster 1 (Knight Profile) 0.9311, Cluster 2 (Guardian Angel Profile) 0.99265, Cluster 3 (Duty Follower Profile) 0.9810, Cluster 4 (Defender Profile) 0.9488, and Cluster 5 (Chameleon Profile) 0.887. James et al (1984) measure the degree of agreement between each member within a cluster: 0 (no agreement) and 1 (total agreement). The results of the five clusters were between 0.88 and 0.99, which indicates quite high internal agreement results. It can be argued that managers within each of the five clusters have very strong agreement about the degree of influence that each of the eight ethical factors plays in their decision-making processes.

Results of the multinomial regression analysis

The multinomial regression analysis results between the five clusters and clinically and non-clinically trained managers shows a model fit of significance; X^2=13.503, p<.009. This result indicates that the null model does not better predict the relationship between the two variables, and therefore there are some significant differences between cluster memberships across the five clusters for clinically

Table 3: Summary of the Empirical Taxonomy of Factors Influencing EDM

	KNIGHT	GUARDIAN ANGEL	DUTY FOLLOWER	DEFENDER	CHAMELEON
Economic Egoism (SS1)	High	Low	Low	Low	Low
Reputational Egoism (SS2)	High	Low	Moderate	High	Low
Act Utilitarian (SS3)	High	High	Moderate	Moderate	Low
Rule Utilitarian (SS4)	High	High	High	High	Low
Self Virtues (SS5)	High	Low	Low	Moderate	Low
Others Virtues (SS6)	High	High	High	Moderate	Low
Act Deontology (SS7)	High	Moderate	Moderate	Low	Low
Rule (SS8)	High	High	High	Moderate	Low

■ Ethical pluralism   ■ Ethical absolutism   ■ Ethical relativism

and non-clinically trained healthcare managers. As can be seen in greater detail in Table 3, it is possible to see that the significant differences appear in the cohorts of clinically trained healthcare managers. For example, the odds of having a Guardian Angel classification relative to a Knight are 3.06 times greater for a clinically trained than a non-clinically trained manager holding any other X variable constant (or a 206% increase in the odds). Another example is that the odds of having a Guarding Angel classification relative to a Chameleon are 2.74 times greater for clinically trained than non-clinically trained managers (or a 174% increase in the odds). However, the measures of fit for the multinomial logistic model are quite low, with Adj Count R2= 0.022, McFadden's R2 =0.10.

Discussion

This research adds clarity to the current stage of the field's evolution by identifying, discussing and further analysing the impact of the degree of influence that diverse ethical principles play on managerial ethical decision-making styles of healthcare managers. The research sets out to develop a taxonomy of ethical decision-making styles amongst healthcare managers and answer three fundamental questions. Firstly, the research was designed to determine the existence of a taxonomy of managerial ethical decision-making in the healthcare industry and understand how many styles there were. The results from the two-step cluster analysis confirm the existence of five well-defined clusters similar to a previous small exploratory study investigating university students and academics and small business owners. [5] In general, this study has found that a five-cluster structure exhibits high internal homogeneity or

a strong degree of agreement within each cluster. [6] The results suggest that each individual manager included in any of the five clusters displays very strong similarities in terms of what influences his/her ethical preferences when making a decision. In addition to that, each cluster exhibits a high external heterogeneity in terms of keeping consistent, significant differences between each cluster (Scheffe Analysis) and, in particular, as shown in Table 2, each cluster represents a unique mix of preferences with respect to the eight ethical subscales.

Secondly, the research aimed to describe each style based on its relationship with the eight subscales. Once the taxonomy had been empirically tested and validated the next step was to discuss the clusters in a way that healthcare managers could identify with and use in a beneficial way in their daily activities. Each cluster was named, provided with a working 'motto' and explained as part of a particular ethical ideology. As outlined in Table 4, by using the results of the five clusters in relation to the eight ethical subscales, five working titles were chosen that encapsulated the essence of each profile. Additionally, five mottos were created to best explain the main drivers of each cluster.

Cluster 1 (N=121): The Knights

These healthcare managers consistently rate all of the eight ethical subscales highly, endeavour to maximise their personal and organisation's values, keep economic factors in focus and consider the impact of decisions on all stakeholders. A manager in this cluster exhibits traits of a Knight – the honorary title given to those people who have demonstrated honesty, faith and courage, and who honour a strong code of ethics. Healthcare managers who exhibit

Table 4: Multinomial Logit Regression Results

	B	Z	P>LZL OR SIG	E^B	E^BSTDX
Knight – Duty Follower	--0.50932	-1.666	0.096	0.6009	0.7796
Knight – Defender	-0.29746	-1.091	0.275	0.7427	0.8647
Knight – Chameleon	-0.11009	-0.341	0.733	0.7427	0.9476
Knight– Guardian Angel	-1.11773	-1.666	0.01	0.3270	0.5791
Duty Follower – Knight	0.50932	-1.091	0.096	1.6642	1.2827
Defender– Duty Follower	-0.21186	-0.702	0.482	0.8091	0.9016
Defender – Chameleon	0.18737	0.588	0.547	1.2061	1.0959
Defender – Guardian Angel	-0.82027	-2.538	0.011	0.4403	0.6697
Chameleon – Knight	0.11009	0.341	-.733	1.1164	1.0553
Chameleon – Duty Follower	-0.39923	-1.149	0.251	0.6708	0.8227
Chameleon – Defender	-0.18737	-0.588	0.557	0.8291	0.9125
Chameleon – Guardian Angel	-1.00764	-2.750	.0006	0.3651	0.6111
Guardian Angel - Knight	1.11773	3.418	0.001	3.0579	1.7270
Guardian Angel - Duty Follower	0.60841	1.730	0.084	1.8375	1.3464
Guardian Angel - Defender	0.82027	2.538	0.011	2.2711	1.4933
Guardian Angel - Chameleon	1.00764	2.750	0.006	2.7391	1.6365

**The reference category is non-clinically trained manager

this profile are ethical pluralists, meaning managers in a given set of circumstances will take into consideration all of the different moral principles in order to arrive at the best possible decision.

Working motto: *'One for all, and all for one.'*

Cluster 2 (N=60): The Guardian Angels

Healthcare managers in this cluster show less focus on those subscales that are directly related to the organisation, such as economic, reputational issues and self-virtues, but display a strong emphasis on the other five subscales. A cluster with this result can be termed Guardian Angels – healthcare managers who not only make sure that they conform to rules and laws but who ensure that the dignity of others is maintained by also keeping an eye on the outcomes. Guardian Angels are strongly committed to fulfilling the obligations that go with a public or professional role and, therefore, they feel a duty to consider the consequences of their decisions and to treat others fairly.

Working motto: *'Patient first, profit second.'*

Cluster 3 (N= 73): The Duty Followers

Healthcare managers in this cluster are characterised by three very strong subscales – Rule Utilitarian, Others Virtue (care ethics) and Rule Deontology – and score lower on all the other subscales. This result suggests a more absolutistic view of ethics, where fewer principles set the standard for what is right or more important in guiding the managerial decision-making process. Therefore, before making a decision, managers in this cluster would consult rules, regulations and laws and then choose the choice that best fits with those criteria.

Working motto: *'Stick to the policies and procedures no matter what.'*

Cluster 4 (N= 118): The Defenders

Healthcare managers in this cluster are strongly influenced by two main subscales: Rule Utilitarian and Reputational Egoism. This profile has been named the Defenders. Healthcare managers in this cluster are very loyal to the organisation and will vigorously protect its reputation.

Honour and reputation are important at both personal and organisational levels, and maintaining a good opinion about oneself and one's organisation can be more important than the bottom line. The Defender would spend more time weighing up what is good versus what is good for the organisation.

Working motto: *'Protecting the hospital's reputation at all costs.'*

Cluster 5 (N=68): The Chameleons

Healthcare managers belonging to this cluster are similar to the Knights as their individual scores for each of the eight subscales are evenly distributed. However, the overall scores are lower than those of the Knights, suggesting that they are open to all influences and possibilities but are not necessarily trying to satisfy equally and concurrently. This profile has been dubbed the Chameleons. Just like the reptile that adapts its skin colour to fit in with its surrounds, these managers draw on each different ethical framework, deciding which is the most appropriate for a particular situation. Arguably, the Chameleons have a realistic view of morality; they do not rigidly hold a particular position but assess the context first and then apply the ethical framework that is most appropriate to that particular situation. While this profile is more flexible than the Duty Followers there is a risk that all of this flexibility could simply encourage decision-makers to blend in with the prevailing culture rather than engaging with it proactively. At best they might be weak pluralists; at worst, they are moral relativists.

Working motto: *'When in Rome, do as the Romans do.'*

Finally, the research sought to understand whether there were differences between the five decision-making profiles for clinically and non-clinically trained healthcare managers. The introduction highlighted the recent trend in which the barriers between administrative and clinical decisions have become somewhat blurred and both clinically and non-clinically trained healthcare managers have been asked to make decisions across both areas. [1] As a result of this trend some arguments were raised that clinically and non-clinically trained managers might see issues through different ethical lenses due to their very different initial industry type and therefore different training and/or education. [7] From the results of the multinomial regression analysis some important points emerge. Firstly, non-clinically trained managers seem to be spread evenly across the five profiles without particular preferences, indicating that this category of healthcare managers covers across the diverse spectrum of ethical principles, from protecting the patient's dignity to optimising resources. Secondly, clinically trained managers,

statistically speaking, seem to have higher odds of being a Guardian Angel rather than a Knight, Defender or a Chameleon. However, due to a very low model fit (R^2) this is only supported for 1% or 2 % of the cases and therefore could not be considered highly significant.

This study has shown that there is no statistical difference between the two cohorts (clinically and non-clinically trained managers) and the five clusters (based on regression analysis results). This is an important discovery as it suggests that the theoretical typology based on job type (clinically and non-clinically trained managers) does not reflect the reality as well as the empirical taxonomy created in this paper, where both cohorts are equally represented in each of the five clusters. Essentially this means that a profile such as the Guardian Angel theoretically should be represented more in those managers that were clinically trained (care for the patient and dignity); this study shows that non-clinically trained managers were equally found in this category.

Limitations

This study, despite its theoretical and practical contributions, has a number of limitations, which are addressed as follows. In terms of the sample used, the first limitation is that all the respondents were working in the Australian healthcare industry, and therefore future studies could be done in different countries to test the possible influence of cultural bias. Another possible limitation of the study sample is the response rate; 17% for an anonymous online survey has been found acceptable in previous studies but in comparison with other studies it could be valued quite low. Therefore, further studies should be undertaken to strengthen the existence of the five profiles, and support their capability to fully represent the overall population of all healthcare managers.

Conclusions

A greater understanding of the taxonomy of managerial ethical decision-making styles can have a range of practical applications for both individual healthcare managers and organisations.

For individual managers an understanding of their own ethical preferences provides useful insights into their managerial style, heightening their self-awareness as healthcare managers. Similarly, understanding the preference styles of managers assists peers and colleagues to comprehend how other managers derive different outcomes based on similar decision inputs. For organisations the taxonomy can be a useful tool in identifying individual ethical preferences (values) of healthcare managers and also the ethical preferences of teams and/or institutional

values in practice (by looking at the percentages that each profiles in a particular unit). As with individual managers, organisations can use the taxonomy to better align the ethical preferences and values of new employees with the organisation. Values alignment is a critical success factor in ensuring key organisational outcomes such as successful organisational change, [8] the formation of organisational culture [9] and rewarding performance. [10]

Understanding the interplay between individual values, espoused organisational values and the values in practice can play an essential role in better understanding the ethical decision-making capacity of healthcare managers. [11,12] For organisations, understanding this interplay between the individual's and organisation's values and managerial decision-making provides a basis for understanding the potential organisational risks with each type of profile when it comes to making critical organisational decisions, particularly in stressful work environments.

In conclusion, the empirical taxonomy developed in this paper provides an important step toward better understanding managerial ethical decision-making in the healthcare industry, while at the same time setting up the background for future research on this topic.

Competing interests

The authors declare that they have no competing interests.

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Appendix 1: Managerial Ethical Profiles (MEP) Survey & Sub-Scales

ITEMS DESCRIPTION	SUB-SCALE				
(1) Providing the highest economic return (profit) for the organisation important	SS1	Extremely important	Very important	Not very important	Not important at all
(2) Minimising costs for the organisation	SS1	Extremely important	Very important	Not very important	Not important at all
(3) Protecting the reputation of the organisation	SS2	Extremely important	Very important	Not very important	Not important at all
(4) Optimising resources of the district/hospital/ unit/dept	SS1	Extremely important	Very important	Not very important	Not important at all
(5) Attaining organisational yearly budgets (short term)	SS2	Extremely important	Very important	Not very important	Not important at all
(6) Being in line with the organisational mission	SS2	Extremely important	Very important	Not very important	Not important at all
(7) Generating the greatest overall benefits for the district/hospital	SS3	Extremely important	Very important	Not very important	Not important at all
(8) Not harming the clients/patients	SS3	Extremely important	Very important	Not very important	Not important at all
(9) Respecting organisational rules and regulations that have been created for the greatest benefit for all stakeholders	SS3	Extremely important	Very important	Not very important	Not important at all
(10) Obeying the law (state and federal)	SS4	Extremely important	Very important	Not very important	Not important at all
(11) Creating the greatest overall benefit for the local community	SS4	Extremely important	Very important	Not very important	Not important at all
(12) Creating the greatest overall benefit for the wider community	SS4	Extremely important	Very important	Not very important	Not important at all
(13) Being most in line with your core personal values	SS5 SS5	Extremely important	Very important	Not very important	Not important at all
(14) Being most in line with the person you want to be	SS5	Extremely important	Very important	Not very important	Not important at all
(15) Respecting dignity of those affected by the decision	SS6	Extremely important	Very important	Not very important	Not important at all
(16) Being able to empathise with clients	SS6	Extremely important	Very important	Not very important	Not important at all
(17) Acting openly when making decision	SS6	Extremely important	Very important	Not very important	Not important at all
(18) Making 'care for the sick' paramount in determining decision alternatives	SS6	Extremely important	Very important	Not very important	Not important at all
(19) Giving the opportunity to all affected parties or their representatives to have input into the decision-making process	SS7	Extremely important	Very important	Not very important	Not important at all
(20) Treating others as you want others to treat you	SS7	Extremely important	Very important	Not very important	Not important at all
(21) Treating people as ends not as means	SS7	Extremely important	Very important	Not very important	Not important at all
(22) Ensuring that confidentiality is maintained at all times	SS8	Extremely important	Very important	Not very important	Not important at all
(23) Maintaining a fair process at all times	SS8	Extremely important	Very important	Not very important	Not important at all
(24) Ensuring that the organisation 'duty of care' is maintained at all times	SS8	Extremely important	Very important	Not very important	Not important at all

The Ethics of Managing and Leading Health Services: a view from the United Kingdom

K Armit and M Oldham

Abstract

The financial challenges facing the NHS in England show no signs of abating. The well-publicised events of Mid Staffordshire NHS Foundation Trust between 2005-2009 show what can happen when leaders and managers focus on finances at the expense of the health and wellbeing of staff and patients. Leading and managing health services in a financially pressured environment is considerably challenging but those responsible for doing so need to learn from the lessons from Mid Staffordshire and be highly aware of, understand and fulfill the ethical responsibilities expected of them.

Expectations of ethical behaviours are well articulated through the NHS Constitution and various professional codes of conduct and standards. Critically, if we want individual leaders and managers, no matter what their professional background, to behave ethically, all the players in the system – professional bodies, regulators, politicians need to create and support the culture and climate in which this can be achieved.

Abbreviations: CQC – Care Quality Commission; FMLM – Faculty of Medical Leadership and Management; TDA – Trust Development Authority.

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Introduction

The challenges faced by those tasked with managing and leading health services throughout the United Kingdom continue to intensify. There is no sign that the financial pressures faced by many are being abated. The well-publicised events of Mid Staffordshire NHS Foundation Trust between 2005-2009 are testament to what can go wrong when leaders and managers focus entirely on the finances to the detriment of their staff and patients. Leaders and managers need to learn from the mistakes of Mid-Staffordshire, understand the ethical frameworks within which they work and have the confidence to behave accordingly.

Those responsible for the financial regulation of healthcare services in England continue to stress that the current level of financial deficit, and any increase on this, is unaffordable.

Recent forecasts (July 2015) show NHS Foundation Trusts sector finishing this year an 'unaffordable' £989m in the red – nearly three times worse than the £349m deficit it recorded in 2014-15. [1] Non-Foundation Trusts had a combined deficit of £473m for the same financial year and whilst the Trust Development Authority (TDA), have not yet announced a forecast for the current year, at their Board meeting in May 2015, the chief executives assessment of 2015-16 plans indicates that the position is likely to become more challenging. [2] At the same meeting the TDA Board confirmed that following a review of the strategic risk register the score in relation to the quality improvement risk was increased, placing it into the 'red-amber' category. This was to reflect the combination of increased quality expectations in the context of increased financial pressures going into 2015-16, stretching the TDA's capacity to support the number of organisations which the Chief Inspector of Hospitals, Care Quality Commission (CQC), has identified as 'requires improvement' or worse. [3]

The reality of this continued financial challenge for local NHS Trust Boards and their management teams is that they have to be absolutely confident that they are sighted from Board to front line on how well their services are being delivered, and what the impact these financial challenges are having directly on patients and staff. They need to be critically aware of the dangers of focusing on finance at the expense of quality.

One of the authors spent four years from 2010 until the Trust was dissolved in 2014, as part of the Board of Directors of Mid Staffordshire NHS Foundation Trust, responsible for ensuring the Trust recovered from its well publicised troubles. [4] In this role, she was well sighted on the dire consequences when a Board becomes divorced from the reality of its organisation. The independent inquiry into the problems of Mid Staffordshire NHS Foundation Trust was damning in its assessment that the Trust Board had become driven by targets and cost cutting. The Francis report was clear that the distress and suffering had been 'unimaginable'. [5] The legacy that the new Trust Board inherited was clear, for executive and non-executive directors alike; they faced a total loss of confidence from staff, patients, and many members of the local community. The new Trust Board recognised that they had an absolute moral responsibility to ensure that patients and staff were never again compromised in the way they were leading up to and particularly during the years 2005-09 [6] - either with the care patients received, or the care staff were able to deliver as a direct consequence of decisions that were made either by the Trust Board, or by national policy directives being introduced without a true understanding of the effect they would have.

No one wants a healthcare organisation to get into difficulty; the consequences can be dire for patients and staff alike. So how can leaders and managers of healthcare services work in a systematic way to ensure they are fulfilling their duties with the upmost integrity at all times?

First and foremost leaders and managers at all levels need to create sufficient time, to enable them to have a presence in front line areas, not just an annual visit to various departments, but a real presence, to be known by and appreciate the efforts of all leaders and front line staff.

Secondly, managers and leaders need to factor thinking time into their week. It is unforgiveable post Francis and Kirkup, [7] for senior leaders not to allow themselves time to simply think during their working week. One of the biggest complaints in modern society overall is that of being overstretched, overcommitted and overextended. It seems to be a human trait that people seem to prefer to be doing something rather than nothing, even if that something is negative. [8] Board members both individually and collectively need time both to consider organisational performance data, to triangulate the many different reports, and as a Board have open and honest rigorous debate. Understanding together what the staff survey is saying about the organisation - would staff be treated in their place of work or recommend it to their nearest and dearest? If not, why not? What's the culture like?

Professor Michael West's highly credible research has clearly linked strong compassionate leadership, staff satisfaction and improved patient outcomes. [9] The evidence is too compelling for senior leaders and managers not to create time to fully understand the culture in the organisations they are responsible for and to develop plans to continually improve it.

Thirdly, all staff, including leaders and managers at all levels need to be prepared for and supported to fulfil their roles and responsibilities. This means getting to know your staff, particularly clinical leaders, supporting their development, and investing time in developing their successors. It is the leaders and managers who establish the organisational climate through their actions and behaviours. The research is clear on the importance of appropriate development, clear objectives, constructive appraisals and teamwork and its link to patient satisfaction and mortality. [9]

Fourthly, being clear on your own, and your organisation's ethical principles and values is essential, as is having a framework to monitor your progress delivering them. Ethical principles refer to well-founded standards of right and wrong. They suggest what humans should do, usually in terms of rights, obligations, and benefits to society. Reasonable obligations are well known and respected in society such as people refrain from stealing, murder, assault, slander, and fraud. Ethical standards also include the virtues of honesty, compassion, and loyalty and cover people's rights such as the right to life, the right to freedom from injury, and the right to privacy. By underpinning how organisations work through an ethical framework, it becomes necessary for senior leaders and managers to constantly examine organisational standards to ensure that they are reasonable and well-founded. Ethical principles also mean 'the continuous effort of studying our own moral beliefs and our moral conduct, and striving to ensure that we, and the institutions we help to shape, live up to standards that are reasonable and solidly based'. [10]

In the NHS, there are well-established codes of conduct for NHS leaders and managers and healthcare organisation Boards, [11-13] these codes all remind NHS employees what is expected of them. In addition, many healthcare professions have established professional codes of conduct and standards. The medical profession has sought to define its own standards for leadership and management. The regulator, the General Medical Council has published guidance on Leadership and management for all doctors [14] and the Faculty of Medical Leadership and Management (FMLM) has established the leadership and management

standards for medical professionals. [15] A system of certification against the FMLM standards is in development.

The NHS Constitution [16] also offers a set of values, principles and pledges, which if used effectively should ensure that organisations do not get into difficulties. Leaders are asked to commit to the values of the NHS Constitution, promoting equality and human rights in the treatment of patients, their families and carers, the community, colleagues and staff, and in the design and delivery of services. The NHS Constitution again reminds managers and leaders that they:

- Are fully accountable for the work and the decisions they make, and crucially that they are also responsible for the decisions of the board and for delegated responsibilities;

- Must act with honesty in all their actions, transactions, communications, behaviours and decision-making, and will resolve any conflicts arising from personal, professional or financial interests that could influence or be thought to influence their decisions as board members;

- Should be open about the reasoning, reasons and processes underpinning their actions, transactions, communications, behaviours and decision-making and about any conflicts of interest;

- Should treat patients, their families and carers, the community, colleagues and staff with dignity and respect at all times;

- Should take personal professional responsibility for ensuring they have the relevant knowledge and skills to perform as a board member and reflect on and identify any gaps in knowledge and skills, and will participate constructively in appraisal of themselves and others while adhering to any professional or other codes;

- Lead by example in upholding and promoting the Standards laid out in the Constitution, and use them to create a culture in which their values can be adopted by all;

- Act with integrity by consistently and fairly applying these values in all actions, transactions, communications, behaviours and decision-making, and always raise concerns about harmful behaviour or misconduct by others.

The NHS Constitution, the professional codes and standards reflect the values laid out in the Nolan Principles. [17] Regulators of healthcare services expect that all senior leaders and managers know, understand and demonstrate they adhere to the Nolan Principles that are the basis of the ethical standards expected of public office holders.

If the ethical frameworks identified above had truly been followed in Mid Staffordshire NHS Foundation Trust then the problems would not have happened. This does not mean the delivery of financially balanced healthcare would have occurred, or that the Trust would have had a future as an independent viable Foundation Trust. Rather it would have forced open and direct conversations both within and external to the Trust with regulators to seek safe viable solutions. It's concerning to see that despite the evidence base and post Mid Staffordshire NHS Foundation Trust, Kirkup and the Keogh Reviews [18] with all the associated learning that NHS organisations continue to be rated inadequate by the Chief Inspector of Hospitals, [19] following Care Quality Commission inspections or placed into special measures by the relevant regulator Monitor [20] or TDA. [21] Opting out of these ethical guidelines is not an option for leaders and managers, they are must do's expected by patients, staff, and regulators.

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Back to the Future: using the Ethical Climate Questionnaire to understand ethical behaviour in not for profits

D L Dark and M Rix

Abstract

The ethical climate of an organisation can be described as the lens by which employees determine what comprises 'correct' behaviour within that organisation. As an outcome of the organisation's culture, many factors influence an ethical climate's design and configuration, including the organisation's history, its structure and management systems, the external environment and the individuals working within it. In order to work out the best ethical structure or ethical framework to support ethical behaviour, ethical climate must first be understood. The ethical climate questionnaire, (ECQ) a tool developed more than 25 years ago, has been applied and refined in empirical research with a focus on private and public organisations, but what about not-for-profit organisations?

Through a focused literature review, this paper finds that the volume of empirical studies involving the ECQ in not-for-profit organisations is quite limited. Sample size, composition of the populations sampled and corresponding diversity in the intent or focus of these studies also limits broader application of their findings.

However, the admittedly limited research findings so far suggest that ethical climates in not-for-profits are different to those found in organisations from the private and public sectors, and cannot be established using a compliance or rule-based approach to instilling ethics and integrity in organisations. Recent regulatory reform in the not-for-profit sector, increased community expectations, and the fact that services are often provided to vulnerable populations suggest a focus on the systems that support and demonstrate ethical decision-making is long overdue.

Abbreviations: ACNC – Australian Charities and Not-For-Profits Commission; CEO – Chief Executive Officer; ECQ – Ethical Climate Quesionnaire.

Key words: corporate ethics; business ethics; ethical behaviour; ethical climate; ethical climate questionnaire; not-for-profit; charity.

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Introduction

Lewis [1] in his seminal study seeking to define business ethics, refers to two points commonly made about ethics. The first is that a person's business ethics cannot be separated from his or her personal ethics, and secondly that business will never be more ethical than the people within it. [1]

An ethical climate can be described as the shared perception and understanding of employees or 'members' of an organisation regarding its norms, values and behaviour. This shared perception defines how ethical issues should be dealt with and what is considered ethically correct behaviour. [2,3,4]

Despite the widespread implementation of ethics and compliance programs by organisations across the private, public and not-for-profit sectors, events continue to occur with a disheartening frequency, with 'concomitant moral collapses of trust among regulators and across the nation'. [5, p.225] Writing in the aftermath of the global financial crisis, Mark Blodgett admitted that 'Business ethics controversies continue to arise in an era of global economic crisis, egregious corporate malfeasance, exorbitant Chief Executive Officer (CEO) compensation, fraudulent investment schemes, proliferation of tort suits, and global human rights abuses'. [6, p.39]

Nevertheless, many private companies, and their counterparts in the public and not-for-profit sectors, continue to adopt codes of ethics or conduct with the expectation (or hope) that doing so will positively affect the conduct of their staff, including executives and senior management, and enhance the standing of the company in the business community and wider society. Patrick Erwin, for example, regards a corporate code of conduct as a symbol of a company's commitment to corporate social responsibility and a practical instrument for governing the behaviour of its employees, which helps to establish a socially responsible and ethical organisational culture. [7, p.535] For Erwin, 'Ideally, codes of conduct affect the organizational culture by governing the actions and conduct of employees through the promotion of ethical business practices, thereby avoiding legal consequences (such as high profile criminal and civil law suits)'. [7, p.536]

Focusing on corruption in the public sector, James Lager insists that developing a code of conduct or ethics first and expecting an ethical organisational culture automatically to follow is really putting the cart before the horse. Despite its accompanying organisational challenges, he recommends that public sector agencies move from a compliance-based approach to ethics to one that has a greater values orientation and is more integrity-based. He points out that 'Rather than emphasizing ineffective and costly approaches to depress the incidence of a specific objectionable conduct, a better approach would be to encourage government agencies to develop and maintain an ethical culture, where the difference between right and wrong is not measured against the terms of prescriptive regulations or legal counsel opinions, but by whether the action is inconsistent with the agency's core values and mission'. [8, p.76-77] This highlights the need for organisations, perhaps especially for not-for-profits working in the social welfare, health, aged care and disability sectors, to ensure that their core values are fully aligned with their vision and mission and that their work in the communities they serve and conduct of their staff at all times exemplify these core values.

Moreover, a values-oriented or integrity-based approach to ethics helps to create a culture where employees are able to discuss ethical issues without shame or embarrassment, are recognised and rewarded for appropriate ethical conduct and in which ethical values are an integral part of leaders' strategic decision-making. A values-oriented and integrity-based approach also helps to establish a good ethical climate 'including better ethical awareness, employee integrity, and the belief that organizational decisions are better because of the ethics program'. [8, p.77] In Australia, the not-for-profit sector is a significant one. Approximately 600,000 entities were identified as belonging to the not-for-profit sector in 2012. In 2013, over 38,000 were registered as a charity by the Australian Charities and Not-For-Profits Commission (ACNC), with a combined income for 2012-2013 of more than $100 billion. [9,10,11]

As in other countries such as Japan, the United Kingdom, New Zealand and the United States, the Australian Government relies on the not-for-profit sector to deliver on social policy objectives by providing services that are considered critical to social cohesion and inclusion in a manner that is believed or hoped to be more efficient and effective than could be achieved by the government and public sector action alone. [12]

Australia's reform agenda commenced in 2012 and follows a similar process to that instituted in Britain and Ireland. New Zealand's Charity Commission was dismantled by the incoming Government in 2012 and merged back into existing departments for efficiency gains. The relatively new ACNC's role was reviewed by the Federal Government in 2015 and at this time is set to remain in existence as the main not-for-profit regulatory agency at Federal level. [11,13,14]

Malloy and Agarwal [2] point to the widespread perception of not-for-profits as being more caring and trustworthy than their counterparts in either the public or private sector not only for individuals but for the community at large. Services are often delivered to people who are not able to afford to pay market prices for them. Not distributing profits to shareholders is assumed to eliminate the agency dilemma and associated costs and stifle any potential for self-interested behaviour by board members (who are mostly volunteers) and executive management. [2,5,15]

However, issues around non-ethical conduct can and do occur in not-for-profit organisations. High profile cases in the 1990s include the Canadian Red Cross where the organisation knowingly allowed blood tainted with Hepatitis C to enter the blood bank, and United Way of America in the 1990s, which included unethical conduct by management relating to expenditure and running satellite businesses under the not-for-profit umbrella with questionable activities and accounting practices. In Australia, the findings of the ongoing Royal Commission into Institutional Responses to Child Sexual Abuse are likely to impact a number of not-for-profit organisations for some time to come. [16,17,18]

The section below provides an introduction to ethical climate theory with a brief account of its history and tracing its contours and links to organisational culture.

Ethical climate theory

Ethical climate theory has evolved from empirical studies of organisational climate across a range of organisations mostly in the private sector. Organisational climate, combined with an individual's own ethical orientation, and the formal systems and rules of the organisation are all considered key variables in shaping the 'ethical tenor' of the conduct of employees. [17]

Ethical climates are considered against the background of an organisation's history, external threats, internal influences, regulatory and professional requirements, the decision-making structures or ethical frameworks that employees operate within, and individual employee factors (such as age, gender and ethical education). [16,17,19]

In the late 1980s, Victor and Cullen [4,19] developed an ethical climate typology, based on a number of theories drawn from psychology, philosophy and sociology, some of which are identified below. The simplest way to explain and describe this typology is as a matrix. Nine ethical climates were identified in the matrix, with the vertical axis representing the ethical reasoning systems, and the horizontal axis representing the frame of reference for decision-making, or locus of analysis. This is represented in Figure 1.

The vertical aspect of the matrix, ethical reasoning systems, is drawn from Kohlberg's individual moral development theory. This theory was founded on the three 'bases' that Kohlberg believed underpin moral judgement and corresponding to what he regards as the three major classes of ethical theory – egoism, benevolence and deontology (also described as self-interest, caring and abstract

Figure 1: Theoretical Ethical Climate types

		LOCUS OF ANALYSIS	
	INDIVIDUAL	LOCAL	COSMOPOLITAN
EGOISM	Self- interest* *(Instrumental)*	Company Profit *(Instrumental)*	Efficiency
BENEVOLENCE	Friendship *(Caring)*	Team Interest *(Caring)*	Social Responsibility
PRINCIPLE	Personal Morality *(Independence)*	Company Rules and Procedures *(Rules)*	Laws and Professional Codes *(Law and codes)*

*Ethical reasoning criterion.
Adapted from Victor and Cullen's [35] dimensions as confirmed in empirical studies, with some climates later renamed by Malloy and Agarwal. [22]

Table 1 - Journal article search method

KEY WORDS	DATABASES
Ethics	Via Summon, databases searched include:
Ethical climate	ABI/Inform Complete
Ethical climate questionnaire (ECQ)	Australian/New Zealand Reference Centre
Not-for-profits	Business Source Complete and Corporate
Non-profits	Education Research Complete
Charities	Emerald Business, Ethics and Law (all)
	Expanded Academic ASAP
	Google Scholar
	Health Business Elite
	Health and Medical Complete
	Health Business Full text
	JStor (all)
	ProQuest Central
	SAGE
	Springer Online Journals Complete
	SpringerLink
	Wiley online

principle). [4,20,21] In investigating possible ethical climates in organisations, Victor and Cullen [4] proposed that an organisation with a primarily benevolent climate would be expected to exhibit a consideration toward the wellbeing of others as the dominant ethical reasoning system. A climate that is classified as principled would predominantly use the application and interpretation of legal and moral principles in ethical reasoning, whereas in an egotistic climate, self-interest would be the dominant system. [4]

The horizontal axis of the matrix is defined as the locus of analysis and this has been derived by Victor and Cullen [4] from sociological theory (in particular, the work of Gouldner) [22] relating to roles and reference groups. The locus refers to the support or reference group in which members of the organisation source their ethical reasoning. The local locus is defined as supporting ethical reasoning within the organisation itself, such as at the level of the team or business unit. A cosmopolitan locus has members of the organisation sourcing their ethical reasoning from somewhere external to the organisation, such as a professional association's code of ethics (especially important for professions such as nursing, medicine, accountancy and the law). For the individual locus, the individual primarily engages and works within their personal ethical framework. [4]

When reviewing the loci of analysis against each ethical reasoning system, the criteria used in making ethical judgements give rise to different dynamics, or contexts. Using egoism as an example, at individual loci of analysis, this basic criterion (self-interest) sees the individual considering their own needs and preferences in terms of their own benefit, or to protect themselves. At the local loci, consideration would be given to what is in the best interests of the organisation (for example profit, market share or competitive advantage). The cosmopolitan locus of analysis defines considerations at a system level of interest (for example efficiency of a particular business system, such as specific components of the overall health care system). [4]

Ethical climate questionnaire

The ethical climate theory framework as outlined above provides the structure around which the ethical climate questionnaire (ECQ) was developed by Victor and Cullen [4] and the items included represent each of the nine theoretical ethical climate types, which were developed out of the original study.

The scale used is a six point Likert scale. Respondents are asked to complete the survey by responding to how it really is in the organisation as they see it, rather than how they would prefer it to be. The assumption is that responders are able to be objective in describing the organisation's ethical climate to others outside of the organisation. To account for any 'filters' that could distort an individual's perception of an organisation's ethical climate, Victor and Cullen have

attempted to emphasise descriptions rather than feelings, and not focus on the individual respondent's behaviour (and whether this is ethical or not). [4]

Since its development the tool has been tested empirically by Victor and Cullen in various organisations [4,19] and utilised in many studies in the for-profit sector, including Weber's [23] seminal work, which found a number of ethical sub climates within a single organisation. It is interesting to note that the repeat study by Weber and Seger did not find ethical sub climates. [24] Cullen, Parboteeah and Victor's [25] study assessed the effect of various organisational ethical climates on organisational commitment. Peterson's [26] study explored unethical behaviour of employees and its relationship with the nine climates (as outlined in Victor and Cullen's original ethical climate framework) and compared this with the five dimensions that had previously been identified in several empirical studies. Recently, Lemmergaard and Lauridsen [27] empirically tested Victor and Cullen's ethical framework on a sample of Danish firms, confirming the strength of the original empirical model with some suggestions for further strengthening of the model.

Methodology

Through the use of key words, a number of relevant business databases were accessed to identify what empirical studies had been conducted using the ECQ in not-for-profit organisations. The search methodology is outlined below.

The review was limited to peer reviewed journals in the English language, and full text articles available online. Studies relating to amateur sporting organisations were excluded from the results. The results of this review are summarised in Table 2.

Table 2: Literature Review summary - use of ECQ in not-for-profit empirical

AUTHORS	SUMMARY OF STUDY	ETHICAL CLIMATES IDENTIFIED
1. Deshpande [16]	Surveyed a single not-for-profit organisation. Also measured 'ethical optimism' and the influence of different ethical climate dimensions on the ethical practices of successful managers. Location: United States Sample size and type: 252 mid-level managers in a single charitable organisation 69% response rate.	Professional, rules, caring and instrumental.
2. Agarwal and Malloy [28]	Surveyed a single provincial sport federation. Location: Canada. Sample size and type: Executives, Board of Directors and coaches. Sample not provided in paper, noting 37% response rate to survey (148).	Individual caring and social caring.
3. Malloy and Agarwal [17]	Follow up of their earlier study, [1] but with a comparison of ethical climates in the government and not-for-profit sectors. Location: Canada Sample size and type: 500 not-for-profit and 500 for- profit managers with supervisory responsibilities. 30% and 46% response rate respectively across government departments and not-for-profit organisations (including charities) in two provinces.	Shared ethical climate dimensions for both sectors included individual, caring, independence and efficiency.
4. Brower and Shrader [29]	Exploratory study regarding the difference between moral reasoning and ethical climate of different board members for seven profit and six not-for-profit organisations. Diverse industries including health care, research, manufacturing and charities. Included interviews. Location: United States Sample size and type: 83 (23 for profit; 60 not-for-profit. Response rate average 62% for- profit, 52% not-for-profit)	For-profit organisations – climates higher in egoism than not-for-profit organisations. Not-for-profit - climates higher in benevolence than for-profit organisations.

Table 2: Literature Review summary - use of ECQ in not-for-profit empirical *continued*

AUTHORS	SUMMARY OF STUDY	ETHICAL CLIMATES IDENTIFIED
5. Laratta [15]	Surveyed social services not-for-profits. Measured relative intensities of ethical climates and included interviews. Location: United Kingdom (seven organisations) and Japan (six organisations) Sample size and type: Executive Directors. 148 (UK), 134 Japan with a 21.6 and 28.4 % response rate respectively.	Both countries – absence of a self-interest climate. Strong intensity of either individual caring or social caring climates. Law and codes strong climate in Japan, whilst independence strong in the UK.
6. Laratta [12]	Surveyed the not-for-profit and government sectors to compare ethical climates between the two sectors. Location: Japan Sample size and type: 500 public officials; 512 not-for-profit executive directors. Net sample of 441 questionnaires (not-for-profit) and 321 questionnaires (for government).	Laws and rules perceived as necessary by both not-for profit and government sectors. Absence of egoism with not-for-profit executives. Individual caring climate (friendship) or social caring climate (stakeholder orientation) high for both sectors.

Findings

Since the development of the ECQ in the late 1980s, a total of six empirical studies using the ECQ in not-for-profit organisations were identified in the database search. Deshpande [16] in his seminal empirical study, used Victor and Cullen's ethical questionnaire to assess the ethical climate in a not-for-profit company in the United States, and also sought to measure 'ethical optimism' so as to assess the nature and range of behaviour by successful managers that was regarded as ethical. The study also examined the influence of different ethical climate dimensions on the ethical practices of successful managers. Deshpande found that the findings supported Victor and Cullen's [4] early work with a single organisation having various types of ethical climates that co-exist within the organisation. However a dominant climate is typically identified. The majority of respondents reported only four different climate types (professional, rules, caring and instrumental). This was different to what had been reported in studies conducted in for-profit organisations by Victor and Cullen [25] who found the additional ethical climates of efficiency and independence in these organisations. Managers perceived a strong relationship between ethics and success when they also observed a greater level of caring and lower levels of instrumentalism (that is egoism) in decision-making. The author recommended that managers should review the perceived ethical climate within their organisation before developing strategies to change ethical behaviour of employees. [16]

Agarwal and Malloy's [28] empirical study of ethical climate in not-for-profit organisations draws from Victor and Cullen's [4] theoretical framework and examines ethical climate by surveying executives, board of directors and coaches of a provincial sport federation in Canada. The researchers applied a slightly modified ECQ from that used by Deshpande, Joseph and Prasad [16,30] and that originally devised by Victor and Cullen. [4]

Agarwal and Malloy's analysis found that two distinct climates emerged, that of individual caring and social caring. This result was different from earlier research by Victor and Cullen [4,25] where it had been found that there was no difference between the loci of analysis relating to the benevolent criteria. [28]

Another key finding of the study is the absence of the local (organisational) locus of analysis, with a focus instead on the individual and cosmopolitan perceptions of organisational ethical behaviour. These findings indicate that individuals may perceive the ethical climate as supporting individual members to reference their own ethical framework or an external professional or legal code rather than the policy, code or rules for organisation they work in or volunteer for. This finding of individual loci reflects the earlier work by Deshpande. [16,30]

Not-for-profit organisations may need to develop a more formal culture and an inward focus on their own systems in order to be able to better connect their members to these systems. This again echoes Deshpande's [16] findings.

Malloy and Agarwal [2] followed up their earlier study with a comparison of ethical climates in the government and not-for-profit sectors in Canada. In comparing identified ethical climates, the authors found that the shared ethical climate dimensions between not-for-profit and government organisations included individual, caring, independence and efficiency with caring ethical climates perceived to be particularly relevant across the two sectors. It was noted by the researchers that this might contribute to the success of collaborations between the two sectors, as there is a common acceptance of benevolence and trust in relationships that are based on the interests of the other.

Malloy and Agarwal observed that only limited empirical research had been conducted on not-for-profit ethical climates from the time of their first study ten years previously. In this study they collaborated with Rasmussen to survey mid-level managers in government and not-for-profit organisations in the health and social sector in one province in Canada. They used unstructured interviews based on the ethical climate theory framework to explore interpretation of ethical climate. Both groups displayed a lack of identification with ego, and equal agreement about the most cost effective way not always being the right way. However not-for-profits found themselves often prioritising cost effectiveness in decision-making due to the perceived need to demonstrate efficient budget management on an often annual basis to government stakeholders. Considerable divergence between the two groups existed with their perception of benevolence, with government managers considering what is best for the public as their focus, and not-for-profit managers considering what is best for the individual client over the broader public. This confirmed earlier work by Agarwal and Malloy. [28]

Another interesting finding related to compliance-based behaviour or following strict legal and professional standards. The public servants interviewed expressed the belief that there was a strong expectation that standards would be followed and this was necessary in the environment they operate within. In contrast, not-for-profit managers were still committed to following the rules but viewed this more as an imposition, with the expectation that those providing services often were required to develop creative ways to meet individual client needs with the resources available, sometimes requiring deviation from the organisation's rules and procedures. [31]

Brower and Shrader's [29] empirical exploratory study examined the difference between moral reasoning and ethical climate of board members in seven profit and six not-for-profit organisations based in the same Midwestern state within the United States. The authors utilised moral development theory based on the work of Rest [21] a student of Kohlberg, and a slightly modified version of Victor and Cullen's original ethical climate questionnaire. In relation to ethical climate, the authors proposed that for-profit and not-for-profit boards are different in their perceptions of ethical climate within their individual organisations and that cultural climate (which they have equated to ethical climate) would impact moral reasoning in different ways when comparing for-profit with not-for-profit boards. [29]

The crossover of cultural climate and ethical climate is disconcerting, as other researchers such as Malloy and Agarwal [17] see the two as quite distinct. They define culture as comprising management's and employees' shared assumptions about how the organisation does and ought to operate. Culture is considered to encompass or incorporate climate. Climate is seen as the shared perceptions of all members of the organisations about how the organisation operates. Climate is thus viewed as a result or outcome of culture.

While Brower and Shrader found in their study that there was no significant difference between moral reasoning in for-profit and not-for-profit boards, they did identify statistically significant differences between ethical climates. For-profit boards were found to exhibit climates higher in egoism than not-for-profit boards. Not-for-profit boards were more likely to employ benevolence ethical reasoning than their for-profit counterparts. [29]

Larratta [15] compared ethical climates across multiple not-for-profit organisations in the United Kingdom and Japan based on the perceptions of Executive Directors (CEOs, Managing Directors, Associate Directors), using a modified version of the ECQ. His finding that an absence of self-interest and a high emphasis on caring climates predominated in both countries appears to confirm previous findings from the not-for-profit sector, particularly that in the work of Agarwal and Malloy. [2,28]

A key difference was identified in the survey results and confirmed during the interviews. This related to the use of rules and law (principles) when making decisions. United Kingdom participants discussed their reliance on their individual moral values and ethical codes with a reduced reliance on rules and law, a finding that was not unexpected. [2,28] However Japanese not-for-profit executive directors strongly identified with law and code when making decisions, whilst still maintaining a benevolent orientation

(such as caring for the good of the community). Laratta claims that this finding refutes Victor and Cullen's [4,19] ethical climate theory and the findings in subsequent studies based on it. [16,32] If Laratta is correct, it suggests that organisations with an individual or social caring climate can and do apply laws and rules as their dominant form of reasoning.

However, in reviewing Laratta's application of the ECQ, it should be noted that a number of the survey statements that participants were asked to respond to commenced with 'decision makers around here' rather than 'people around here' as in earlier studies. Thus it raises the question of whether Larrata's research was measuring the organisation's overall ethical climate (or climates) or just the ethical climate at the CEO level. If it were the latter, it would be important to know whether the CEO level perception of the ethical climate reflects the ethical climate as perceived by organisation members across the whole organisation.

Laratta's second study [12] used the ECQ to survey the not-for-profit and government sectors in Japan to compare ethical climates with a view to understanding the differences and similarities between the two sectors. A slightly modified version of the ECQ tool was used, and this included a translation into the Japanese language. In this study, Laratta [12] found that there were a number of similarities between the ethical climate perceptions of executive directors of not-for-profits and government officials. Universal laws and rules were perceived as necessary by both sectors. This reliance had been identified for not-for-profit executives in Laratta's previous study. [15]

Also identified was a lack of identification with egoism with not-for-profit executives, along with strong perceptions of belonging to either an individual caring climate (friendship) or social caring climate (stakeholder orientation) for respondents from the two sectors. The primary concern of both groups was the well-being of others and to do what was best for users of the organisation's service (individual responsibility) and the community as a whole (social responsibility). These findings support earlier work by Malloy and Agarwal, [2] and those of the other studies reviewed in this paper. [12,16,29,31]

Discussion

Commonality in findings between studies includes a general lack of egoism, an emphasis on caring, benevolent climates and the absence of an organisational or local referent or focus. These findings suggest that formal policies and rules regarding ethical decision-making may not be as effective in

a predominately caring climate type because rules and codes perhaps do not have the same importance to organisation members. In fact, a caring climate with an individual or cosmopolitan locus of analysis would place the welfare of individual care recipients, or indeed society as a whole, as being of greater importance. This may cause organisation members to override, overlook or circumvent existing organisational policies and rules. However this could vary between countries and according to their different cultures, traditions and histories.

It is important to acknowledge that all of these the studies have shortcomings, including limited sample size, [28,29] response rate, [15] being limited to a specific management group, [12,15,28,29] or only conducted in a single country. [12,16,17,29] As already highlighted, many of these studies also mostly focus on executive and board level members of not-for-profit organisations, which offers limitations on what the actual perception of ethical climate for organisation members is at the service delivery level.

Although there have only been limited studies of not-for-profits and their ethical climates, there is a common theme that the ethical climates that exist in not-for-profit organisations are distinct from those found in the for-profit sector. The revision of Victor and Cullen's ethical climate theoretical framework for not-for-profits, as proposed by Malloy and Agarwal [17] has some resonance with the findings common to all of the studies. Their revised model provides a potential platform for further fruitful exploration in the sector. This updated model or framework is outlined in Figure 2.

Conclusion

Ethical frameworks are a reflection of the ethical climate (or climates) of the individual organisation. Therefore, in order to change or improve the ethical framework in an organisation, one must understand the existing ethical climate, and what the organisation wishes it to be. [4,25]

The ECQ as developed by Victor and Cullen provides organisations with an opportunity to identify what their members perceive to be the ethical climate in their particular organisation. Since its development in the late 1980s, the tool has had limited application in not-for-profit organisations, with only six empirical studies completed thus far and, with some exceptions, [12,17] all with limited sample sizes and scope of application. The use of the questionnaire has varied considerably but it is interesting to note that no study has utilised the questionnaire to get a cross-section of perceptions for all levels in a single organisation, as was its original intent. [4,25]

The application of the ECQ in the not-for-profit sector mirrors research using the ECQ in other sectors. Arnaud, [33] a critic of the tool and its usefulness, reports its application in approximately 75% of ethical climate research but makes little comment about the variations in the tool itself across different studies or of how it has been applied by them. In contrast, Simha and Cullen [34] note the inconsistent application and modification of the tool, which makes it difficult to compare findings across studies.

In reflecting on the lack of focus on ethical climate research in the not-for-profit sector, a combination of factors is suggested to have influenced this outcome. These include an initial and necessary concern with improving efficiency of not-for-profit business models, and the diverse and fragmented nature of the sector itself. These factors have often resulted in different government agencies having inconsistent and sometimes competing regulatory interest in the sector, diffusing the impact of regulatory pressure for greater accountability in the sector. [12,16,17,31]

Implications

With the recent changes in regulatory landscape and subsequent raised expectations of accountability for not-for-profit organisations, including in Australia, it is timely that further consideration is given to the ethical climates of not-for-profit organisations, and their alignment with government and stakeholder expectations.

Of the limited research conducted so far, it is interesting and not unexpected to note that different ethical climate types have been identified in the not-for-profit sector as compared with the private and public sectors.

These findings support earlier comment by several writers that the implementation of more rules and policies simply may not work. Structures to support ethical decision-making (such as a code of conduct, ethics training and whistleblower programs) within any organisation can't be effective until the existing ethical climate is understood.

With ongoing regulatory reform in the sector, and an increasing focus on reputational risk, what kind of ethical climate will a not-for-profit be expected to have and nurture in the future?

Competing interests

The authors declare that they have no competing interests.

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Do Health Inquiries Lead to Health System Change? What Have we Learnt from Recent Inquiries and Will the Same Mistakes Happen Again?

G E Day and G L Casali

Abstract

Since 2001 there have been numerous Commissions of Inquiry into health system failures across the world. While the Inquiries were established to examine poor patient outcomes, each has identified a range of leadership and management shortcomings that have contributed to a poor standard of patient care. While there is an acknowledgement that different heath systems have different contexts, this paper highlights a number of themes that are common across Inquiries. It will discuss a number of common system failures in Inquiries spanning from 2001 to 2013 and pose questions as to why these types of failures are likely to re-occur, as well as possible learnings for health service management and leadership to address a number of these common themes.

Abbreviations: ACHS – Australian Council on Healthcare Standards; ACSQHC – Australian Commission on Safety and Quality in Healthcare; NHPA – National Health Performance Authority.

Key words: health inquiries; management; leadership; governance; patient safety.

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Introduction

Since 2001, there have been a number of Inquiries and Royal Commissions into health system failures in Australia, as well as internationally. Most notably in Australia, Inquiries into public health services in Queensland, [1,2] New South Wales, [3] Victoria [4] and Western Australia [5] have dissected failures in health service delivery and patient care. Similarly, health system failures have been investigated in New Zealand [6] and the United Kingdom. [7-11] Reviewing the outcomes of Health Inquiries over an extended time period provides an opportunity to reflect on underlying issues that impact on safe, quality care as well as how leadership and management play a significant role in the safe delivery of health services.

From a national context, the Australian health system has introduced a number of bodies to provide monitoring and assessment of health service quality and performance aimed at improving patient care and clinical outcomes. Bodies such as the Australian Council on Health Care Standards (ACHS), the National Health Performance Authority (NHPA) and the Australian Commission on Safety and Quality in Health Care (ACSQHC) provide services that attempt to safeguard and improve patient care and safety through monitoring, surveillance and the introduction of compulsory standards. [12] Similar approaches have been used in the United Kingdom with the establishment of the National Patient Safety Agency to improve patient care.

While increasing standards and health system reporting is driving change in Australian healthcare delivery, [13] it remains a 'people' business and healthcare managers are required to make decisions that have budgetary, staffing and patient outcome implications every day, with these decisions having profound effects on service delivery. To understand the breadth of health system failures, it is important to review a number of the Australian and International Commissions of Inquiry to assist in understanding common themes or areas of concern. It is interesting to note that all of the Inquiries, (See Table 1) while called for the purposes of poor clinical outcomes or patient deaths, are highly critical

Table 1: Selected Commissions of Inquiry

YEAR	INQUIRY	PURPOSE	TOTAL RECOMMENDATIONS	LEADERSHIP, MANAGEMENT OR GOVERNANCE RECOMMENDATIONS[#]
2001	**Douglas Inquiry [5]**	Inquiry into Obstetric and Gynaecological Services at King Edward Memorial Hospital	237	151
2001	**Kennedy Inquiry [14][@]**	Investigation into children's heart surgery at the Bristol Royal Infirmary1984-1995	198	119
2002	**Paterson Inquiry [6]**	Investigation into Southland Health Board (NZ) Mental Health Services	53	53
2002	**Thwaites Inquiry [4]**	Inquiry into the operation of the Royal Melbourne Hospital	58	56
	Davies Inquiry [1]	Commission of Inquiry into Queensland Public Hospitals instigated to primarily investigate complaints of poor care and patient deaths by Dr Jayant Patel at the Bundaberg Hospital	23	8
2008	**Garling Inquiry [3]**	Special Commission of Inquiry into acute care services in NSW public hospital	139	98
2013	**Francis Inquiry [8]**	To investigate the complaints of poor care in the NHS Mid-Staffordshire Trust	285	18

\# Recommendations based on the development of new services, practices, protocols, structures and funding.

@ Original Inquiry report unavailable. Results based on the content of the United Kingdom Government response to the Kennedy Inquiry recommendations.

of absent leadership, flawed management practices, missing governance and poor decisions by health managers.

While there are local contextual issues that drive each Health Inquiry, there are opportunities for broader health system improvements that jurisdictions can consider as a result of understanding the common themes; and by implementing strategies based on the lessons learned from these Inquiries. From an Australian perspective, while it is important to understand the issues from a local context, understanding the outcomes of Inquiries, particularly from the United Kingdom are insightful. [15]

Methodology

The official reports of six major health system Inquiries from 2001 to 2013 were reviewed and recommendations related to leadership, management and governance were analysed. Content analysis of these recommendations identified six main themes. Common themes that appeared across three or more of the Inquiries were subjected to further analysis and relevant quotes from these Inquiries were included.

Results

Six key themes were identified across the six Inquiries that have implications for the leadership and management of health services, irrespective of the local context. These include: leadership and management; working relationships between clinicians and managers; politicisation; resources; bullying and intimidation; and access to information.

Leadership and management

Excerpts from a number of Inquiries demonstrate the links between leadership and management and their profound impact on patient care and safety. Six inquiries over 13 years all highlight issues with management, leadership and governance that led to serious clinical outcomes and deaths for a number of patients (Table 2). It could be argued that the Inquiries identified a lack of managerial focus, concentrating more on budgets and targets rather than on the patient. The following Inquiry excerpts show that serious leadership and management deficiencies continue to exist, with similar underlying issues re-occurring with each Inquiry.

Table 2: Inquiry Excerpts related to Leadership and Management

THEME	INQUIRY COMMENT	YEAR OF INQUIRY
Leadership and Management	'For example, investigation and analysis may show that a problem arises not only because of policy or procedural deficiencies but also because of underlying cultural or organisational factors such as poor management or lack of accountability. Changes to the policies or procedures alone, while they may have a superficial attraction, are unlikely to resolve the problem'. [5, p.xx]	2001
	'Staff considered there to have been a lack of accountability, a failure to include staff in decision-making, a lack of vision and too much focus on fiscal matters. This resulted in mistrust of management, poor staff morale and a drop in standards of care for patients'. [4, p.2]	2002
	'It highlights poor organisation, failure of communication, lack of leadership, paternalism and a 'club culture' and a failure to put patients first'. [14, p.1]	2002
	'The second aspect was the focus, dictated by the budget, upon elective surgery throughput. Dr Patel made himself so valuable in that respect that the administrators were plainly reluctant to offend him, let alone investigate him'. [1, p. 6]	2005
	'. . . a new culture needs to take root which sees the patient's needs as the paramount central concern of the system and not the convenience of the clinicians and administrators'. [3, p.3] 'Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from manager ial and leader ship responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care'. [8, p.3]	2008

Table 3: Inquiry Excerpts related to Working Relationship between Clinicians and Managers

THEME	INQUIRY EXCERPT	YEAR OF INQUIRY
Working Relationship between clinicians and managers	'I discussed earlier how administrators have triumphed over clinicians, at the expense of patient care and safety. This is likely to continue unless clinicians are given greater control in this respect.' [1, p.364]	2005
	'I have identified one impediment to good, safe care which infects the whole public hospital system . . . It is the breakdown of good working relations between clinicians and management which is very detrimental to patients. It is alienating the most skilled in the medical workforce from service in the public system'. [3, p.11]	2008
	'The Inquiry heard evidence that added justification to the view formed at the first inquiry that clinicians did not vigorously pursue with management concerns they may have had. The reason for this was in part a perception that the raising of concerns was not welcome by senior management, and in part the very human reluctance to risk job security and potential opprobrium'. [11, p.174]	2013

Table 4: Inquiry Excerpts related to Politicisation

THEME	INQUIRY EXCERPT	YEAR OF INQUIRY
Politicisation	'. . . advised Board members that after discussion with the Minister, it was quite evident that he was hoping for a great deal of cooperation between the two Hospitals, however, he would not be satisfied with the soft approach . . . he would be most likely, if this option were taken, to engage external consultants to review the Hospitals. If consultants were commissioned to undertake such a review, the resulting report could be more stringent and ultimately less favourable to KEMH's interests. [5, p.111] 'I think there was a great deal of suspicion at King Edward that this was really the first step in the closing of the Hospital and that it would be brought under the wing of PMH as the larger hospital – probably we would close the site down and relocate it. There was a lot of suspicion amongst a number of the senior medical staff that that was what was the ultimate aim.' [5, p.116]	2001
	'. . . the politicisation had become intense, and it had a negative effect on the provision of services'. [1, p.47]	2005
	'. . . whilst the NHS is separate from Government at a constitutional level, the Government of the day does not treat it as an independent entity'. [10, p.1267]	2013

Working relationship between clinicians and managers

There were striking similarities between the Davies, Garling and Francis Inquiries [1,3,11] in relation to the breakdown of effective working relationships between health service managers and clinicians, as illustrated in Table 3.

It is clear that strong professional working relationships between managers and clinicians are central to ensuring a coordinated approach to improved patient care and outcomes. [3] It is critical that each party knows what contribution each brings to the team to collectively focus on patient outcomes.

Politicisation

Politics and health services often go hand in hand. However, when it interferes with patient care it can have serious implications for the patient. Inquiries since 2001 (Table 4) have shown increased politicisation of health services, particularly in funding, rationalising services and meeting or maintaining targets.

Resources

The recent health systems failings in the NHS Mid Staffordshire Trust Inquiry revealed the tension between patient care, the needs of the greater health system and the role healthcare staff, particularly managers. Often in this interplay, the patient gets forgotten. While the Mid Staffordshire Trust Inquiry [8] stressed 'putting patients first', the fiscal tensions remain largely unchanged in the system and, as such, it is highly likely this scenario will be repeated again. These themes were also evident in 2005 and 2008 in Australia. [1,3]

Resourcing and funding are common recurring themes over multiple Inquiries. Inadequate resourcing has taken the focus away from patient care issues and largely turned them into statistics or an outcome of the budget process (Table 5).

Table 5: Inquiry Excerpts related to Resources

THEME	INQUIRY EXCERPT	YEAR OF INQUIRY
Resources	'The Inquiry found the structural changes from 1995 until 2000 had an adverse impact on staff morale and standards. They coincided with complexities experienced by all metropolitan hospitals including the financial implications of scientific and technological changes, increased public scrutiny, increasing demands for services, long waiting lists, higher patient acuity and shorter length of stay, widespread nursing shortages and increasing use of casual staff.' [4, p.2]	2002
	'The plight of public hospital funding was worsened by a philosophy of economic rationalism rather than patient care and safety. The 'efficiency dividend' was one indication of this. Others were the concept that Queensland Health was 'purchasing' services from public hospitals, and that patients were 'consumers' of those services. Similarly, the system of elective surgery budgets focused on throughput and revenue rather than the outcomes of the patient and the community. ' [1,p.354]	2005
	'I would describe our hospitals as good by world standards, in many cases ranking towards the top, but too often unable to deal with the sudden increase in patients, the rising cost of treatment, and the pressures on a skilled workforce spread too thinly and too poorly supported in the dozens of administrative tasks which take them away from their patients.' [3, p. 3]	2008

Bullying and intimidation

Over 13 years and three Inquiries, forms of bullying and intimidation were evident (Table 6). These were seen as either ignoring problems or threatening staff not to make problems public knowledge. Either way concealing deep-seated clinical service problems to avoid embarrassment or not understanding the gravity of the situation compromised patient care. Interestingly, the bullying and intimidation is many ways closely aligned with the increasing politicisation of the health system.

Table 6: Inquiry Excerpts related to Bullying and Intimidation

THEME	INQUIRY EXCERPT	YEAR OF INQUIRY
Bullying and intimidation	'Over the last 11 years, responses from those in a position to do something about a particular problem commonly included: • ignoring the problem; • denying that there was any problem; • criticising those who suggested that there was a problem . . .' [5, p.xvi-xvii]	2001
	'This culture started at the top with successive governments misusing the Freedom of Information Act 1992 to enable potentially embarrassing information to be concealed from the public. Unsurprisingly, Queensland Health adopted a similar approach, and because inadequate budgets meant that there would be inadequate healthcare, there was quite a lot to conceal. Again unsurprisingly, the same approach was adopted by administrators in public hospitals, and this, in turn, led to threats of retribution to those who saw it as their duty to complain about inadequate healthcare.' [1, p.345]	2005
	'The first inquiry report identified a number of cultural themes which were associated with the deficiencies that had been identified. They were summarised as: • Bullying; • Target-driven priorities . . . ' [9,p.1361]	2013

Table 7: Inquiry Excerpts related to access to information

THEME	INQUIRY EXCERPT	YEAR OF INQUIRY
Access to information	'. . . the importance of high quality, timely information. It recognises that the exchange and provision of information is at the core of an open and honest relationship between healthcare professionals and patients; that information about the performance of the NHS is the basic building block of any system of standards and quality; that information needs to be analysed and used to inform practice…' [14, p.110]	2002
	'To achieve this reform, I have recommended that a Bureau of Health Information be established to access, interpret and report on all data relating to safety and quality of patient care and facilitate its interpretation and re-issue to the unit level on a regular basis. The information collected is to be directed to how well the patient has been treated, not to process-driven, often politically-driven, data which may make administrators more comfortable, but not the patients.' [3, p.4]	2008
	'It is a cardinal feature of the Stafford story that information that would have led to the much earlier appreciation of the problems of the Trust was either not collated, not analysed or not disseminated. The result was that commissioners, performance managers, regulators and the public remained unaware of the extent and significance of the issues for f too long.' [9, p.1615]	2013

Access to information

Clinical and business information is critical, not only to business operations but clinical decision-making. Multiple Inquiries highlight the lack of information (Table 7) for clinicians and managers and the need to have better systems and processes for underpinning safe, cost effective and robust decision-making.

Discussion

Despite the raft of Inquiries and subsequent recommendations since 2001, similar themes re-occur. The questions that may be asked include:

- Despite the number of well-publicised Inquiries, such as the Kennedy, Davies and Francis Inquires, [1,7,8] why do similar themes re-occur? and

- What leadership and management approaches could be considered to improve safe, quality patient care going forward?

While it might be sensible to assume health system improvements would build on the learnings from previous Inquiries and address underlying themes, this critique has demonstrated this is not the case. Russell and Dawda [15] correctly point out the challenge is in the remedy rather than the diagnosis when it comes to implementing inquiry recommendations. This assertion provides some insightful understanding into why there appears to be similar threads through a number of Inquiries, and may include:

- Inquiries make non-binding recommendations. Inquiry recommendations include words such as 'consider' and 'should' and recommendations are 'optional'. Commissions of Inquiry, or Royal Commissions, while able to compel witnesses to give evidence, deliver findings and recommendations that are non-binding. This is opposed to Coroners Courts that may hand down binding recommendations, albeit limited to a single jurisdiction;

- As many Inquiries are inherently political, implementing any recommendations is dependent upon the will and budget of the government of the day or subsequent governments; and

- Inquiry recommendations often offer technical solutions to what is fundamentally an adaptive problem. [16] Technical solutions offer short-term 'band-aid' resolution, when deep, sustained culture change is what is required.

As a result of these themes, the question should be: what leadership and management approaches could be considered to better understand and address these themes to improve safe, quality patient care going forward?

Healthcare organisations might consider the following activities as a way of addressing these themes:

- Strong decision-making and accountability frameworks for health service managers are imperative. In 2010, Casali and Day [18, p.73] examined the link between ethical decision-making and organisational culture as a result of the Inquiry at Bundaberg Base Hospital. At that point the authors argued '. . . ethical decision-making capacity of healthcare managers remains at the front line in the battle against unethical and unprofessional practice'. This still holds true today;

- Organisations actively discussing previous and current Inquiries with staff and managers with a view to self-assessing services for similar themes; [19]

- Implementing frameworks for safe patient care that are underpinned by proactive, focused governance structures and leadership; [17]

- Actively improving the culture and climate of the organisation through developing collaborative models between clinicians and managers; [15, 20]

- Increasing the awareness, function and ongoing education of the pivotal role of being a health service manager; [21] and

- Deeper understanding of the politics of health [22] and how a manager's decision can be influenced by the politics rather than the practice of healthcare.

This paper has identified a number of common themes that run across multiple health inquiries into poor patient outcomes. While organisations and health systems have different drivers and contexts, some common underlying themes deserve further scrutiny and examination. This review invites health managers and leaders to create dialogue and further examination of these themes and implement strategies that underpin long-term solutions to safe, quality patient care.

Competing Interests

The authors declares that they have no competing interests.

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Leading Ethical Decision-Making: Clinical Ethics Services in Australia

J Jones and E Milligan

Abstract

Decision-making in healthcare demands consideration of not only the clinical, operational or financial aspects of care but increasingly complex ethical issues. Meeting the physical and emotional needs of patients ethically, while acknowledging the distress and conflicting expectations and needs of staff, can be extremely difficult for all involved. It is vital that staff be provided with a 'safe space' to speak of the ethical challenges they are encountering if we are to take staff safety as seriously as we take patient safety. A Clinical Ethics Service (CES) established in accordance with the recently released National Health and Medical Research Council (NHMRC) consensus statement and the *NHMRC Clinical Ethics Resource Manual* can provide such a space.

This paper explores the who, what and why questions embedded in ethical decision-making. The work of a CES will be outlined. Drawing of the Roger L Martin's concept of heroic leadership, stakeholder roles and moral orientations will also be explored. In addition, the often unspoken attitudes towards certain patients, 'likeable' and 'unlikable' for instance, which threaten to influence views of 'worthiness' of care will also be explored.

Abbreviations: ACHS – Australian Council on Health Standards; CEC – Clinical Ethics Committee; CES – Clinical Ethics Service; NHMRC – National Health and Medical Research Council; SDM – Substitute Decision Maker.

Key words: clinical ethics services; ethical decision-making; staff safety.

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Introduction

Decision-making in healthcare demands consideration of not only the clinical, operational or financial aspects of care but increasingly, complex ethical issues demand our attention. Meeting the physical and emotional needs of patients, while acknowledging the distress and conflicting expectations and needs of staff, can be extremely difficult for all involved. Everyone, including leaders, need aware-ness of their own values and beliefs as these largely drive expectations and behaviour when faced with such ethical decisions. [1] Importantly, as our values and beliefs can also impinge upon our ability to hear and understand opposing views, it is equally critical to understand and challenge the values and beliefs of other stakeholders, including organisations, and the culture in which they are entrenched, if full appreciation of any situation is to be gained. In addition, often unspoken attitudes towards certain patients, such as 'likeable' and 'unlikable' for instance, threaten to influence views of 'worthiness' of care. It is vital that staff be provided with a 'safe space' to speak of the ethical challenges they are encountering if we are to take staff safety as seriously as we take patient safety. A Clinical Ethics Service (CES) established in accordance with the recently released National Health and Medical Research Council (NHMRC) consensus statement [2] can provide such a space. The accompanying *NHMRC Clinical Ethics Capacity Building Resource Manual* [3] provides a useful resource for organisations wishing to establish such a service.

This paper explores the role of a CES in assisting staff, who in turn support patients, by identifying and addressing issues such as moral distress, [4,5] compassion fatigue [6,-9] counter-transference, [10,11] understanding futility, patient vulnerability and autonomy, and the challenges these issues raise in ensuring the best ongoing care of all patients regardless if they are like us or not. It draws on the operationalisation aspects of a CES situated in a large Australian tertiary hospital in order to highlight the capacity building, practical support and ethical guidance such a service offers to both the practitioners and leaders of a healthcare institution. This service was established in 2008 and has assisted well over 700 staff per year with capacity building opportunities through small and large groups continuing professional development initiatives. In terms of providing practical support to clinicians, this service has assisted clinicians and executive directors at least once per month since its establishment. While the service has not yet undergone a specific evaluation/validation process, through its accreditation and credentialing processes, the hospital has been noted for having exemplary practice in terms of the provision of resources to assist and guide clinicians in their ethical challenges and associated complex decision-making practices. Of note, the CES also contributes to the hospitals Australian Council on Health Standards (ACHS) Equip National accreditation contributing to staff and patient safety (Standard 1 – Governance for Safety and Quality), and Standard 15 (Systems and Delegation 15.6 – Ensuring governing body involvement throughout the ethical decision-making process). [12]

What is a Clinical Ethics Service?

While clinicians are generally very skilful at sensitively and effectively navigating the ethical issues arising in care, the plurality of moral views in our increasingly heterogeneous society has given impetus to the establishment of clinical ethics services within Australia to provide an additional layer of support. [13] Technology use, and the inherent complexities this brings, has also cast a more focused lens on the ethical challenges of clinical care. [12] Some hospital accreditation processes in Australia, such as the ACHS, further acknowledge the role of embedded clinical ethics services in improving governance and decision-making in healthcare. [13] Currently in Australia there is no formal structuring, coordination or professionalisation of CESs. The approach generally adopted by existing Australian services therefore largely aligns with that advocated by the American Medical Association:

[CES] is educational and advisory in purpose. Generally, the function of the ethics committee should be to consider and assist in resolving unusual, complicated ethical problems involving issues that affect the care and treatment of patients within the health care institution. Recommendations of the ethics committee should impose no obligation for acceptance on the part of the institution, its governing board, medical staff, attending physicians, or other persons. However, it should be expected that the recommendations of a dedicated ethics committee will receive serious consideration by decision makers. [12, p.151]

Kerridge, Lowe and Stewart note that the assistance of a CES may be sought in cases *'where the goals or outcomes of care are interpreted differently by different individuals and where conflict arises due to explicit moral or philosophical disagreement'.* [12, p.151]

The service of which the lead author is the coordinator has primarily adopted the approach outlined above. The main functions of the service are threefold:

1. to assist staff build capacity by means of providing educational opportunities;

2. to provide practical support to clinicians by means of ethics consultation; and

3. to support and guide the ethical climate of the organisation by means of policy review and development.

While there are many different models and structures in the way CESs can be set up, in our case, the CES is coordinated by a Clinical Ethicist, who performs these functions with the support of a Clinical Ethics Committee (CEC).

What does the Clinical Ethics Service do?

• 'Identifying the ethical aspects in the case' and 'getting the facts'

In general terms, a Clinical Ethicist initially adopts a 'problem finding' approach when called upon to guide and support clinicians navigate their way through a conflicting or challenging case situation. Some authors refer to this process as the first two steps of the CES process, i.e. 'identify the ethical problem' and 'get the facts'. [12, p.140] Such problem finding starts with who, what, why questions. For example, who are the stakeholders involved in this particular case? What values do these stakeholders hold? What triggered this requested change in treatment pathway? Was it prompted by a felt ethical conflict? If so, why has this conflict arisen at this particular time?

• **Stakeholder perspectives: exploring the who, what, why questions in this case.**

Whenever a case is referred to a CES or a CEC, the primary stakeholder should be readily recognised as the patient and his/her supportive carers. In respecting the principle of autonomy, due consideration must be given to the patient's right to autonomy and capacity to participate in discussions about her/his healthcare and capacity to provide informed consent. If such capacity is not deemed to be present, then the hierarchy of decision-making should be invoked with the patient's substitute decision maker (SDM) having the right to make decisions regarding care and treatment options. If no SDM is available then referral to the Public or Adult Guardian would be the next appropriate step to ensure that decisions made are respectful of the patient's autonomy and in his/her best interests.

The attending team – which, in complex situations, is likely to consist of practitioners from multiple medical disciplines and practices such as nursing, allied health etc – are also stakeholders. Therefore, their ethical orientations and values must also be considered. A primary value and ethical orientation of these stakeholders, and the general community, is the sanctity of human life and the protection of such. Daniel Callahan defines such an ethic as one built on the principle that *'every being that can biologically be justifiably described as human, and who has done no wrong, ought to have its life protected*. [14, p.18] Callahan further contends this principle 'is fully compatible with the stopping of medical treatment when it will do the patient no further good'. [14, p.18] When practical support by means of an Ethics Consultation is sought, tension or distress, which arises from differing philosophical or moral positions or as a result of goals and outcomes being interpreted differently, is often present, as noted earlier. [12] For instance, in cases associated with the question of futile treatment, clinicians will likely be experiencing an ethical tension between the sanctity of life and the requested/desired treatment. However, consideration must primarily be given to the extent to which practitioners may feel funnelled towards a conclusion of futility when they are unable to reconcile their ethical and moral orientations must also be considered. Framing a situation as 'futile' may have been a professionally tolerable 'way out', a circuit breaker to an untenable and deeply distressing situation.

Both the hospital (represented by the executive team) and the broader community (in the form of other and future patients) are also stakeholders. Healthcare resources in Australia are finite, and although public funding may create cultural expectations about 'free' and unlimited healthcare, all treatment cannot reasonably be made available to all patients at all times. Health managers, charged with the ethical responsibility of 'just' allocation of these finite resources in the broader interests of the community, may understandably seek to question the ongoing cost and opportunity cost, inherent within this ongoing cycle of care with apparently limited benefit. Uncomfortable as it is to acknowledge, resource allocation is unavoidably an ethical issue. [7]

• **Understanding stakeholder roles and moral orientations**

Our assumptions or attitudes about groups of people may subtly shape how we believe we should provide care for them...the attitudes of healthcare providers may not reflect the patient's reality and may affect the care provided [16, p.38]

Vulnerability is an inherent feature of being human – each and every one of us is at risk of *'physical, psychological, or emotional harm'.* [16, p.37] In navigating our way through such vulnerability it is widely acknowledged that we draw on shared cultural understandings that often consist of familiar, readily understood patterns or stories. [17,18] Despite the increasing attention given to the patient's voice, practitioners often see themselves as 'fully' responsible for their patients' welfare – they see themselves as 'heroic leaders' [19] in the recovery and/or rehabilitation of their patients. Through such 'heroic' behaviour they are frequently positioned (by themselves and others) as *superheroes or rescuers*. Patients, on the other hand, may be typically characterised as passive recipients of care, who are either *'good/worthy'* i.e. likeable, compliant and thankful, or *'difficult/unworthy'* i.e. unlikeable, aggressive, non-compliant or ungrateful. [20,21] Such positioning of practitioners and the dichotomous stereotyping of patients is both supported by and supports the 'unwritten rules of healthcare': 'the guiding values'. [19, p.9] Closely associated with such apportioning of perceived responsibility positioning of practitioners and patients is the ever present cycle of over-responsibility and under-responsibility. [19]

Roger L Martin contends that relationships are vulnerable to *'the Responsibility Virus'*; a phenomenon *'by which parties vacillate unproductively between heroic leadership and passive followership'* with a cycle of over-responsibility and under-responsibility ever present. [19, p.4] In positioning clinical staff in the role of superhero or rescuer, the burden of over-responsibility is taken up by, or placed upon them. Consequently, in positioning the patient as passive follower/recipient an expectation of under-responsibility is present.

[19] The Responsibility Virus is recognised as being driven by a fear of failure that results in the 'responsible' party claiming a disproportionate share of power. Inevitably, as the burden becomes too great, both parties enter a continually vacillating *'cycle of over/under responsibility'*. [19, p.8] Drawing on the work of others, Martin contends that 'governing values' or 'rules' guide the way we interpret and deal with our world. [19, p.9] Like the dominant narratives we are embedded in, we are largely unaware of these 'rules' or 'values' until a disruption highlights that we have become out of sync both in terms of the expected narrative, and our expected roles within.

As noted earlier, an ethics consultation is often sought *'where the goals or outcomes of care are interpreted differently by different individuals and where conflict arises due to explicit moral or philosophical disagreement'*. [12, p.151] In providing practical support, the role of the clinical ethicist is to pose questions that help tease out our own and others' moral orientations which may, in turn, 'provoke or demand a complex range of practical responses'. [22, p.2] Questions such as 'is the patient a "likeable" or "unlikeable" patient? Does she/he provoke in us a sense of allegiance, or a core value such as justice or as a desire to help? Or does she/he trigger feelings of dislike and distrust?'. Such questions are inherently important as the 'likeable' patient – the good/compliant patient – is often seen as more worthy of time and attention as *'compliance is not only assumed to be in patients' best interests, but is also equated with a "social good"'*. [20, p.282] The 'unlikeable' patient – the patient who challenges, refuses or resists – on the other hand, often has her/his behaviour labelled as 'irrational' and 'deviant'. [21, p.306] Such patients are typically '*viewed as hindering the "normal" process and practice of health care'* [21, pp.306-307] and therefore 'unworthy' of our time and attention. In making unfounded judgements, avoiding such patients or labelling them as difficult or troublesome, staff are at risk of violating professional boundaries. With the help of a CES, staff can be supported to recognise their own motivations, values and expectations as *'internal reactions need to be attended to, understood, and in one way or another, managed'*. [15, p.411] Acknowledging that negative feelings towards patients exist can seem almost 'unsayable'; however, the ability to recognise these feelings as an unavoidable part of clinical life, is the first step in providing practical education, structure and support for staff to appropriately manage them.

How does a Clinical Ethics Service help? Building capacity and supporting resolution

Interactions between patients and health care professionals are at the heart of health care. These interactions have an essential ethical dimension that may at times be challenging. Supporting professionals and organisations to meet those challenges can help ensure that patient care is provided in an ethically appropriate manner [2]

By focusing on the non-clinical aspects of care with the Clinical Ethicist, and later through the CES, the conflicting expectations, values and positions of stakeholders can be elicited and worked on. Key considerations in terms of staff include moral distress, compassion fatigue, counter-transference, and the identification of treatment as medically or clinically futile. For the patient vulnerability and autonomy are key considerations.

The guidance provided by a Clinical Ethicist creates a 'safe space' for staff to speak of the ethical challenges they are encountering. Through the provision of this safe space, staff gain increased clarity and support, which in turn builds confidence, promotes understanding and increases individual and organisational capacity for ethical decision-making. Furthermore, through the expression of differing disciplinary treatment options, a shared re-alignment of goals and desired outcomes is likely to be achieved. A collaborative approach to care allows each staff member feeling more confident, supported and validated. However, it is often noted that the real benefit of the CES consultation is the validation of moral concerns and the burden of responsibility acknowledged and, in part, relieved. The presence of hospital executives as members of the CEC may further assist in this validation of feelings and demonstrate a genuine commitment to building a sound ethical culture in the hospital with sharing of responsibility.

For patients and their families, the increased clarity, consistency and transparency of shared treatment plans help set clear boundaries; more actively respects autonomy and promote greater patient responsibility.

Conclusion

Complex ethical decisions arise in healthcare on a daily basis. While most staff feel equipped to meet the clinical challenges of their work, many will feel uncertain at times when confronting the complex ethical terrain of healthcare. Access to a CES can provide staff support, build

individual and organisational capacity and foster a culture and climate in which patient and staff care is driven in an ethically mindful way. As accreditation bodies increasingly recognise the benefit of CES in improving governance and decision-making in healthcare, we anticipate that more healthcare organisations will recognise and acknowledge the importance of staff safety by implementing such services as a resource for staff. For more information on how to establish and run a CES, please see the NHMRC Consensus Statement on Clinical Ethics and the *NHMRC Clinical Ethics Capacity Building Resource Manual*. [2, 3]

Competing interests

The authors declare that they have no competing interests.

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Do our Leaders have the Technical Expertise to Lead Health Sector Reform?

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Abstract

The healthcare delivery paradigm has changed. This requires health care leaders implementing reform to think differently. It requires organising ourselves differently and even behaving differently. It is incumbent on health professionals with technical skills, experience and expertise to remain cognisant of the changing landscape, culture and community, understand patient and community expectations and lead development of a new vision, strategy and clinical systems and processes.

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Introduction

Providing leadership in as complex a sector as healthcare requires expertise in a wide range of arenas – from clinical systems and process improvement, to technology and innovation, to financial management. Of course, leadership is about showing the way, influencing and persuading to take a particular action, [1-3] however, it becomes difficult if the leader does not have the technical expertise to understand and manage complexity in healthcare delivery, set and communicate a vision and have the ability to understand what the evidence-base, clinical effectiveness evaluations as well as technology and population health impact assessment may be highlighting.

An added complexity for a healthcare leader is the pace with which the sector is developing and evolving. To manage change, not just in a sociological sense, but in technology, innovations, systems and processes, requires a leader to be an all-rounder who has the knowledge, speed and awareness, all of which require technical expertise.

Pace of change in healthcare delivery is fast – very fast

Over the last two decades the world seems to have changed quite dramatically – and medicine is no exception. [4] Of course, over time one expects change. However, when change is exponential and across multiple domains with the introduction of new drugs and technologies; novel models of care, new ways of analysing, accessing, using and communicating information, it can sometimes become difficult to keep pace and make quick adaptations. [5]

We are also experiencing a cultural change. Since the 1980s and 90s both what we did and how we did things have changed, some would suggest dramatically. Learning the art of healthcare delivery for most professionals often started before dawn and finished post-dusk. Documentation was a beautifully crafted narrative. There was a sense of ownership of `my patient.' Everything had to be checked by us as we just couldn't rely on other checks and balances in the system. Relatively few cost constraints meant we got what we needed to practise our craft and there were few managerial constraints to sign off on every purchase.

Contrast that to the world of healthcare today – fast paced, protocol-driven, resource constrained, population health focused, with technical checks and balances, more explicit accountabilities, guided by decision support tools and cost considerations driving how many interventions of what type, whether unplanned or elective, can be undertaken.

The concept of `my patient' is fast becoming redundant, even for the remaining solo medical practitioners. Instead, it is expected that a patient-centred and team-based approach will deliver a coordinated `package of care' comprising of a series of well-coordinated transactions delivered by several health professionals, each with a high level of skills and expertise in their area.

This change in expectation and culture, along with the growth in health expenditure of approximately 7-8% annually over the last decade has made governments concerned about our ability to sustain this level of continuous growth. [6] The question is – how should the healthcare system respond to deliver what is needed now and into the future to be able to deliver the most efficient, effective, productive and patient-oriented healthcare system? [7]

Technical leadership may be the key

Leaders that position us for tomorrow must have a good understanding of health systems and processes, but they must not just be coordinators, facilitators and transactional managers. To be able to deliver healthcare into the future, there is a need for effective technical leadership at all levels of healthcare organisations. The need is for leaders who can devise system and process improvement solutions to enable delivery of more efficient, highly effective and less wasteful care. Leaders who can understand both costs as well as benefits of new technology, and challenges and opportunities offered by the introduction of new models of care delivery. Leaders who can analyse demographics, community expectations and the impact of community interventions and can suggest change in the way we practise.

To achieve the above, it becomes incredibly important for leadership to do what is often neglected – to take stock of the changed world of healthcare delivery, understand new expectations health services need to fulfil, appraise how well those expectations are being met and lead the change to meet those expectations. This necessarily involves continuously assessing performance of both the system as well as individuals within this system. This calls for leaders with general experience and common sense, but also technical skills in healthcare systems and processes.

The complexity of providing leadership in healthcare lies in having skills and expertise to ensure safe service delivery; ensuring treatment effectiveness considerations guide optimisation of service delivery; evidence base and best practice considerations determine what should be provided, by whom and how change should be implemented; technology and innovation is continuously assessed for use; delivery systems and processes are continuously improved; understanding of supply and demand considerations to ensure that best value is delivered for the consumer, community and society in general and models of care; and therefore the workforce is continuously configured and aligned to deliver the most effective and appropriate interventions possible.

How can we get there?

Perhaps, an important aspect of healthcare leadership at this time is to lead and manage organisations in line with ongoing reform initiatives. Over the past two decades, the health sector has seen a number of reforms. The architects of each and every reform not only had a vision but also developed a strategy to support that reform. Every change promised improvement, sometimes foreshadowing transformational change. Even though many reforms did not deliver to expectations, the effort was well-intentioned.

Most of these reforms have had common themes, which are themes that are likely to influence the healthcare reform process in the shorter term. One key reform theme in almost every Australian healthcare jurisdiction has been `system integration'. [8] There is an acknowledgement that the Australian healthcare system is fragmented and that there are several different funding streams and multiple healthcare providers that are organisationally independent of each other, with little opportunities for coordinating services for those with multiple co-morbidities. Could it be that we know what needs to be done, but either lack the technical system and process expertise to implement, evaluate and improve?

Another common theme in healthcare reforms has been a need to achieve allocative and/or technical efficiencies. Consequently, more time and energy is devoted to achieving good financial and activity performance which is often seen as a key determinant for the success of a reform initiative. Inevitably there is a focus on `budget days,' budget preparation, performance meetings, public reporting, league tables and other quasi-'name and shame' strategies. There is a desire to see improvement in health outcomes; even an appreciation that healthcare innovation, practice improvement and a change in the model of care is needed, however, the upfront cost and investment makes us hesitate to invest in the redesign of clinical systems and processes, in new technology and in innovation. We continue to live in hope that focus on financial and activity performance itself will provide a trigger for improvement of clinical systems and processes.

From a clinical perspective, an important consideration for reform and improvement has been whether our systems and models of care meet patient needs, and do so efficiently and effectively. If we accept that we now need to re-conceptualise our systems and processes around the patient and their needs, this may require thinking about healthcare structures and functions differently. We may need to re-consider how we organise ourselves to deliver healthcare and also how healthcare is delivered.

For example, in the past we organised ourselves in `divisions' to ensure the patient with specific needs could come to a specialist division (of cardiology, nephrology, psychiatry, etc.) or to a specific service (inpatient and outpatient services). We insisted on the separation of primary care and specialist care systems, on a system of referrals and discharges. We ordered tests, prescribed treatment and made follow up appointments. If the services must now organise around the patient with a focus on delivering the entire package of care that the patient needs, it may just need a major redesign of facilities, systems and processes that are centred around the patient, around actual or perceived burden for them and their carers, and an organisational system that makes the care flow most efficient and effective.

Re-configuring organisational structures and redesigning clinical care pathways always is, and will be challenging. However, unless we change how we are structured and how we function, we will continue to remain preoccupied with counting the number of interventions, the length of time spent in one organisational unit (e.g. a hospital bed) and its cost, rather than trying to measure care delivery across settings, effectiveness, whether we are delivering appropriate care, meeting patient and community expectations and achieving improved outcomes.

Conclusions

To manage complexity and change, there is a need for leaders with technical expertise to understand evidence, technology, innovation, value, complexity and change. Undoubtedly bringing about a cultural change to ensure the healthcare system has capacity to accommodate innovation and change is going to be essential. A leader who has the technical skills and expertise in the above areas is likely to be more able to deliver.

Many in the profession in leadership positions who have gained technical expertise over the years must understand the current paradigm of healthcare delivery and clearly outline the adjustments that are necessary, based on evidence and technical analysis. If that means organising ourselves differently and even behaving differently, it is important that those propositions are supported by evidence and technical analysis and using knowledge as well as technical expertise to improve systems and processes.

Competing interests

The author declares he has no competing interests.

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Raising the Bar for Health Leadership in Australia

A Sebastian

Abstract

An insider's view of two national conversations leading to an agreed and approved health leadership framework for Australia, this perspective highlights the national aspirations for developing leadership for a people focused health system that is equitable, effective and sustainable. Admired in Canada and in many places around Australia, development of the tools and programs to accompany Health LEADS Australia faltered in the transfer of custodianship from Health Workforce Australia to the Department of Health. On hold too, is a national approach to health leadership built into early career education and professional development. Despite this, authors and stakeholders in State and Territory Health Departments and independent health agencies are using Health LEADS Australia in ways that continue to highlight its potential for raising the bar of health leadership in Australia.

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Health LEADS Australia is on the one hand, only a leadership framework. On the other, it represents a serious attempt to forge a national health leadership movement intended to collaboratively produce and use evidence-based tools and programs, introduce leadership thinking earlier in health education and training, and maximise the return on investment in leadership development. The journey has been an interesting one and is perhaps, not over yet.

A decision was made to focus on building leadership for the sustainability of the health system in Australia on the basis of a national consultation held in 2011. In this consultation, health service managers, clinicians, colleges, consumer bodies and healthcare workers, were given the opportunity to choose five national priorities for 'health workforce innovation and reform'. They made Leadership for the Sustainability of the Health System their third choice. [1] Intuitively felt and described on the basis of practice and experience, this choice was well supported by emerging evidence from Australia and beyond. [2]

Why did these people want to raise the bar on health leadership in Australia? Did they mean management? Was there a perception of differences between leadership and management? Did the one mean disrespect for the other?

These questions and others were explored in a second national consultation in 2012. It was quickly established that the healthcare practitioners, clinical and non-clinical involved, shared a strong conviction that the Australian health system would only thrive in the face of challenges being experienced on the ground and documented in a major national report in 2009 [3] if leadership were significantly improved. These people meant leadership not management and they knew and articulated the differences. While there was widespread acknowledgement that health leaders are often also managers who would benefit from better understanding of leadership and how to lead, there was also a view that significant health leadership comes from non-managers. It was argued that greater respect and understanding of the differences between leadership and management would make more space for 'distributed' acts of leadership, from young clinicians, patients, non-managers and others working in hospitals and non-hospital based health services.

Participants conveyed conviction that the emphasis on good management, processes, guidelines and standards

was in some places, taking over in non-productive ways. Reductions in the passion and care for improving health were described, along with the sapping of energies and abilities of leaders from chief executives to front line staff to speak up for transformative change and to show more care for clinical outcomes. Participants identified particularly, the need for leaders to have greater self-knowledge and emotional intelligence and to engage respectfully with people from other professions, disciplines and cultures, those without high-level positions and those using services. They expressed concern that diligent management alone would not be enough to challenge sometimes oppressive hierarchies, and investments in unsustainable healthcare methodologies. Driving innovation and shaping systems were also supported as essential capabilities for health leaders.

The context then and now is an increasingly brutal reality that, despite all the wonders of a first class health system, without changes, it will not be sustainable in the long run and the health and well-being of the population will not be as good as they might.

In the two national consultations, people in health indicated they want to do better. 'Karpin Revisited' [4] backs this sense that we can and should do better. Enquiring into our progress since 1995 when Enterprising Nation [5] was published, this 2011 work identifies that while as a country we have done much to improve management capabilities and education, our leadership understanding and development will benefit from greater development.

Others have noted the human inclination to revert under stress to known behaviours and habitual patters. Graham Dickson [6] notes that in the case of health service manager/ leaders, the stress reversion is to management of the status quo rather than more visionary and collaborative aspects of the leader that are sometimes required.

Stories of leadership abound in health and often have simple principles at their heart. Someone, or a small group, identifies a need, a gap, a poor practice or a greater goal and sets out to remedy or achieve it. They rally others to their cause and demonstrate credibility through integrity, consistency and respect for people in all areas of the issue. They articulate a direction and demonstrate focus in pursuing it, sometimes in the face of great obstacles and even personal attacks and derision. They draw on inner knowledge and strength and keep questing for improvement, knowing that focus is not the same as rigidity and that sometimes the leaders' path requires the balance and flexibility of a dancer along

with the tenacity of ivy. They build alliances, consider the evidence, seek out and respect others strengths they lack and they drive improvements; they are more prepared to try and fail than to risk not achieving the dream. And the more they delve into their personal reserves, sometimes encountering illness and unexpected vulnerabilities, the more they understand and appreciate the need to see the whole system and the whole person, and how they work, or could work better together. From Florence Nightingale and Fred Hollows to patient and clinical advocates such as Dr Sonia Fullerton and others leading the 'hello my name is.' campaigns, [7] we have and do recognise leadership in health when we see it.

While there are many who question the efficacy of current discussions about leadership, [8,10] participants described large sections of healthcare as sometimes hostile or non-responsive cultures with attendant risks for leadership development, particularly where this is of a broad-based, distributed type. Their view was that in these contexts, leadership discourses help counter established hierarchies of relationships within health services, encourage trans-formative initiatives and embolden health managers to assist in making the significant differences the Australian health system requires. Independent, thoughtful management they argued, nuanced by deep understanding of leadership, can make positive differences to organisational climates, patient and consumer well-being, and to clinical and agency outcomes.

Such differences are needed in health systems in many developed countries. Francis [9] for example, identified 'a culture (in the NHS) focused on doing the system's business, not the patients'.

Some authors such as Checkland, [10] are dismissive of the idea of distributed leadership and think it risks denigrating the value of occasional acts of heroic leadership. Yet around Australia, people spoke of an agreed approach to leadership that could hold to principles of shared and distributed leadership based on the belief that all people can contribute to bettering the healthcare system. Critics said in the consultation 'if everyone is a leader, who will follow and who will do the work?'. They miss the point. If everyone learns about leadership and is prepared to play their part at some time, the quality of followership will improve. Loh [11] notes that all great leaders must first learn to follow and Chaleff's [12] work on courageous followership 'recognizes that to be effective at almost every level of an organization, individuals need to play both the leader and follower role adeptly'. [13]

Australians engaging in the consultation were not by and large, given to binary thinking. Often managers themselves, they understand and respect the craft of management. Caring and thoughtful also, they saw its limitations in the health systems and sometimes, in themselves. They wanted to learn to manage and lead better and to be part of something optimistic, goal driven and simple enough to recollect without recourse to charts and texts. These views underpin the formula that became Health LEADS Australia. [14]

Approved in 2013 by the Australian Health Ministers Advisory Council (AHMAC) as the national health leadership framework, Health LEADS Australia has not yet been developed as anticipated in the consultations. Planned outcomes included a suite of freely available and collaboratively developed tools and programs to optimise the utility of the framework; grounds for national approaches to universities to embed health leadership in early career education and in post-graduate learning; and iterative and contextual development of case studies, stories and examples to enhance the relevance of the national approach to the diverse professions and community interests in health.

An Australian-Canadian partnership was optimistically formed with declared mutual interests in shared development programs and research into the value of national health leadership development approaches.

Undeveloped, Health LEADS Australia still exists as the only nationally approved health leadership framework and remains potentially a national instrument for raising the bar in health leadership in Australia.

It is currently hosted through, although not being actively used by, the Health Workforce Division of the Australian Department for Health. [15] It has in the past two years, been used in Leadership and Management programs in the Department of Health and Human Services, Tasmania, [16] has a 360 degree feedback tool in use in another Australian state and in a third, is being developed alongside management capabilities to guide the training of positional leaders. Health LEADS Australia is used in a recent and significant text as the organising principle and thus, 'provides a contemporary approach to understanding the key leadership and management attributes across the five critical domains: leading self, engaging others, achieving outcomes, driving innovation and shaping systems'. [17] In Western Australia, the Clinical Senate in considering levels of physician engagement has recommended WA Health 'pick up on Health LEADS Australia and other work'

to 'develop a clinical leadership framework that outlines the competencies required across all levels of the clinical workforce'. [18, p.7]

While these initiatives are encouraging, the real potential of Health LEADS Australia for raising the bar in health leadership in Australia lies in the nationally collaborative development of tools and programs that can support the surge in capabilities needed to achieve the goal: Leadership for a people focused health system that is equitable, effective and sustainable. [19]

Competing interests

The author declares she has no competing interests.

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The Challenges of a Relational Leadership and the Implications for Efficacious Decision-Making in Healthcare

H Harden and L Fulop

Abstract

Objective: To demonstrate how decision-making can be made more efficacious in healthcare contexts, such as cancer care networks, by adopting relational leadership practices.

Design: Empirical material was collected through video-recordings over a 12-month period of fifty-three meetings of seven cancer networks in Australia. Using an interpretive approach, analysis was conducted on the meeting conversations of service improvement sub-committees of the networks. Only one sub-committee was described as 'narrative rich' meaning, personal narratives or stories were evident in their conversations. The sub-committee is characterised as displaying elements of multi-ontology sense making. Drawing on the Cynefin framework, conversations were classified as simple, complicated, complex or crisis-based depending on the nature of their decisions and the contextual constraints. This allowed conversations to be tagged as examples of either single or multi-ontology sense making.

Setting: Cancer networks in Australia tasked with the dilemma of enhancing multi-disciplinary cancer care.

Main outcome: Relational leadership practices can generate narrative rich conversations in decision-making through enabling multi-ontology sense making.

Results: Sufficient evidence was found to demonstrate that narrative rich conversations offered potentially new and innovative ideas for service improvement but lacking relational leadership practices, networks simply produced interventions that amounted to 'more of the same.'

Conclusions: The ability to skilfully relate helps create contexts in which multi-ontology sense making can flourish. Skilful relating, as a leadership practice, is essential to making healthcare professionals more innovative and creative in how they deal with organisational dilemmas, allowing them to engage in robust, informed and inclusive decision-making processes.

Key words: relational leadership practices; healthcare service improvements; efficacious; decision-making.

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Introduction

This paper examines the implications of relational leadership practices on decision-making in service improvement sub-committees of cancer networks in Australia. Decision-making events can be important exemplars of leadership [1] and the implications of this for healthcare have recently been theoretically explored using a relational leadership perspective. [2] Given the dominance of the biomedical paradigm, and its influence on the clinical managerial domain in healthcare, [2-5] a significant leadership challenge is to change decision-making approaches from deeply embedded single ontology sense making practices,

to incorporate multi-ontology sense making, especially where the nature of care is complex. Single ontology sense making refers to the reliance on fact and expert opinion during decision-making whereas multi-ontology sense making refers to the incorporation of narrative evidence to supplement factual knowledge and expert opinion.

This paper introduces a relational approach to leadership as decision-making using the constructs of skilful relating and multi-ontology sense making. Skilful relating is important for understanding the decision-making challenges of difficult dilemmas in healthcare and how they might be overcome. In the absence of skilful relating, fact and expert knowledge (or single ontology sense making) will prevail during decision-making. Empirical material from the meeting conversation of the sub-committees of the cancer networks is presented. The sub-committees were established as a vehicle to enhance multi-disciplinary care. The empirical material presented demonstrates how opportunities for creative and innovative solutions to certain types of dilemmas were not taken up. The paper discusses the implications for decision-making efficacy of leaving single ontology sense making approaches unchallenged in such contexts.

Background

In this paper leadership is conceptualised as skillful relating, most evident when multi-ontology sense making occurs

in the decision-making process. The relational leadership approach adopted here conceptualises leadership as an individual or collective process and a leader(s) is recognised as such, irrespective of any formal leadership role, by how others view their contributions to decision-making that occurs in solving dilemmas. Critically, leadership is socially constructed through interactions with others. [6,7] Leadership is about negotiating and sustaining a flexible social order that does not simply build consensus but allows for new and different points of views to emerge to foster change and innovation. [2] In highly professional settings, such as healthcare, the challenge to maintain flexible social ordering is fraught when confronting the bio-medical paradigm and its corollary, single ontology sense making. Leadership comes down to influencing what gets left on or off agendas and gets attention as distinct to being side-lined, forgotten and/or foregone. Relational leadership is very much about influencing and changing contexts so that new and different ways of seeing a problem can emerge, but the end game is to be able to practise multi-ontology sense making.

The Cynefin Framework is an applied framework for understanding complex decision-making [4,8] and is used in this research to describe decision-making in terms of multi-ontology sense making and framing leadership as skilful relating. For example, Table 1 highlights four possible

Table 1: The Cynefin Framework, decisions in multiple contexts

	SIMPLE	COMPLICATED	COMPLEX	CHAOS
Danger signal	Complacency Make complex problem solving simple. Draw on factual knowledge. Entrained thinking. No challenge to current wisdom. Over-reliance on such things as best practice.	Experts overconfident in own solutions or efficacy of past solutions. Analysis paralysis. Non-expert views excluded.	Temptation to fall back into habitual, command-and-control mode. Temptation to look for facts rather than allow new patterns to emerge from narrative-based conversations. Desire for accelerated resolution.	Applying command-and-control approach longer than needed. Cult of the leader. Missed opportunity for innovation. Chaos unabated.
Response to signal	Create communication channels, to challenge orthodoxy. Stay connected without micromanaging. Don't assume things are simple. Recognise the limit and value of best practice.	Encourage stakeholders to challenge expert opinions. Use experiments to force people to think outside the familiar.	Allow for reflection. Use approaches that encourage interaction so new patterns can emerge.	Set up mechanisms to take advantage of opportunities of chaos. Encourage advisors to challenge your point of view once the crisis has abated. Work to shift the context to complex.

decision-making contexts (simple, complicated, complex and chaos) and a fifth disorder, which was left off this table and denotes the place from which all decision-making starts. Table 1 also refers to three possible sources of knowledge (fact, expert opinion and narrative). To stay locked into a simple and complicated domain is to be practising single ontology sense making, which in healthcare means giving primacy to the biomedical paradigm, as distinct from entertaining multiple paradigms. Skillful relating is concerned with creating a flexible social ordering where all five domains are recognised and can be used. The Cynefin Framework also helps explain what constellations of social ordering, such as the five domains, come to shape the discourse in localised settings. It is through discourse-in-practice that localised meanings are created in everyday talk, such as the three types of knowledge mentioned above. [2,9,10] Skilful relating is about destablising particularly entrenched forms of social ordering so that different discourses can emerge. For example, relational leadership supports and encourages multi-ontology ways of solving problems along the lines suggested in Table 1.

A relationally oriented approach to leadership as decision-making views leadership as a sense making process whereby participants influence and negotiate a social order that advances the achievement of a task, goal or a project. [11,12] This process of negotiation is enacted through discursive practices that provide resources and tools as culturally accepted ways of thinking and working

and for making decisions, that also encourages disruptive ways of working and thinking. The cultural meanings that constitute particular discursive practices are communicated and worked upon through discourse-in-practice. Discursive practices are therefore an integral part of, and influenced by, localised discourse-in-practice. [9,13] It is the interplay between both that accounts for how people can construct one reality as opposed to another and why it is difficult to change from one form of social ordering to another. During decision-making, participants have to create a context that reflects their collective preference for a particular kind of social ordering. The social processes that can be involved in this contextualising of dilemmas are shown in Figure 1.

For example, decision-making begins in disorder, whether for a short time or becomes ongoing, and will ultimately lead to particular values and interests being favoured over others. [2] For leadership to achieve a multi-ontology decision-making approach requires a social ordering that is sufficiently flexible to handle the cognitive, social, political and emotional processes that emerge from disruptive or uncomfortable change. The key is ensuring that decision-making is not prematurely tied down to single ontology sense making and a rigid social ordering when presented with particular organisational dilemmas. [2] These four processes underlie relational leadership practices but our concern here is explaining the importance of multi-ontology sense making to this practice.

Figure 1: The re/contextualising processes of professional sensemaking during decision-making
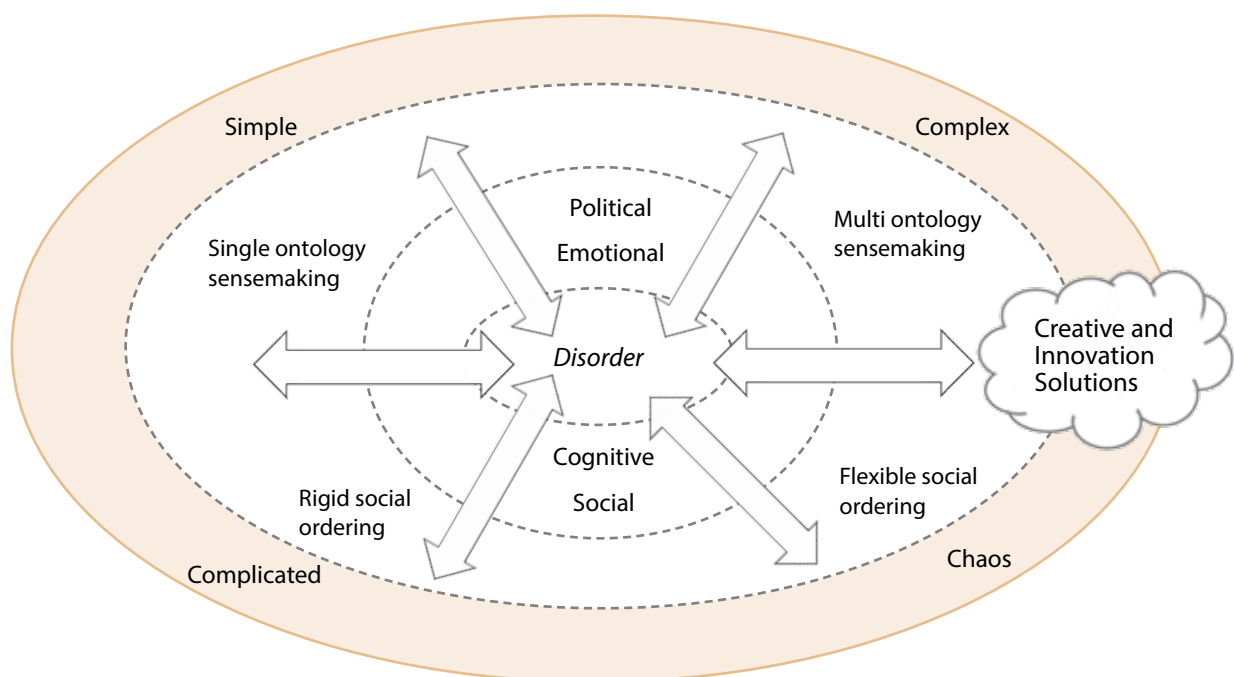
The encouragement of multi-ontology sense making in healthcare (as a way of dealing with disorder) requires, at the very least, the presentation of narrative evidence and ultimately the incorporation of such evidence routinely into decision-making. However, narrative is not typically a feature of many decision-making efforts and clinicians may need some assistance if narrative is to become a part of their routine decision-making in solving complex dilemmas. [2,5,14,15] If multi-ontology sense making is to be achieved, decision-making processes must be handled skillfully to face the challenges that a professional sense making context presents. Participants can therefore be identified as more or less skillful in decision-making [16] by their contributions in conversations to achieving multi-ontology sense making that helps unsettle taken-for-granted assumptions that seem to be highly favoured and resistant to change. [9] There is no leader-centric logic here but an opportunity for anyone to step forward and engage in narrative conversations when dealing with complex organisational dilemmas.

Method

The Cynefin Framework, institutional talk and several other interpretive tools, were brought together in a novel approach to empirically examine skillful relating, incorporating multi-ontology sense making and more broadly, leadership as decision-making. The empirical material used in this study comprises fifty-three video-recordings of the meeting conversations of seven cancer network sub-committees over 12 months. The video-recordings were captured as part of a preliminary quantitative study of the social interactions of the sub-committees during decision-making. Typically there were 8-10 participants in each meeting conversation from across medical, nursing, allied health and management disciplines. One network, identified as 'narrative rich' relative to the others, and therefore having the potential for multi-ontology sense making, was selected as a case study for detailed qualitative analysis. An analysis of the institutional talk of this 'narrative rich' sub-committee was completed on a sample of three meeting conversations.

An institutional talk approach [9,17] examines particular characteristics of talk in relation to its institutional setting and takes into account that the institutional setting may place particular constraints on social interaction. [17] To further strengthen the contextual sensitivity of institutional talk analysis, thematic analysis, [18] turning point analysis, [19] and the Cynefin Framework [1] were used. Thematic analysis [18] was used to generate empirical material on the issues that were the focus of the network's decision-making. Turning point analysis was used to identify particular

types of interactions that changed the course of decision-making. The Cynefin Framework was used to describe discursive practices and discourse-in-practice in terms of single and multi-ontology sensemaking. This approach to institutional talk analysis was novel and aimed to identify what is distinctive about an institutional interaction and its leadership implications for decision-making. The meeting conversations were analysed using the inter-related dimensions of institutional talk, which included, turn-taking organisation, overall structural organisation, turn design, sequence organisation, lexical choice, and asymmetries in institutional interactions [17,20] to show how discourse in practice transforms, and is transformed by, the discursive practices of an institutional setting. Given the word limits of this paper, it is only possible to present typical examples of meeting conversation for each of the key constructs of interest: multi-ontology sense making and skilful relating.

This research was approved by the Griffith University's Research Ethics Committee as well as two hospital Research Ethics Committees with a strict condition not allowing the identification of networks or their members.

Findings

A key overall finding is the lack of narrative evidence in the conversations of the networks. Even when it was present, it was not sustained in any efficacious way. The reasons for this are now outlined.

Multi-ontology sense making

Turn taking was centred on the contributions of the chair who directed the conversation towards management and organisational issues. For example, as illustrated by the extract of conversation in Appendix 1, while discussing the importance of focusing on the health of patients, the network members talk about how the language of cancer care needs to change from being about enduring treatment to survivorship. Even though the network members perceived this shift in language represented a significant cultural change for most cancer teams, they were passionate about the need for this practice change to happen. However, when the sub-committee begin to explore the role of the network in bringing about this culture change, their enthusiastic discussion (Appendix 1, lines 13-41) is curtailed by the enactment of a turning point, made by the chair, 'Oh, all right. Coming back to our need for three goals, short term, medium, long term' (Appendix 2, lines 43-44).

Appendix 1 shows a typical example of how the discursive practices of the chair shape network talk and the contextualising that reinforces inflexibility. The chair

introduces the topic of conversation, 'I wondered about focusing on health after treatment, it gives it a new language, it gives a patient focus'. The chair follows up with expert opinion, 'I read this really interesting article about how we use language around cancer' (line 3), to give her chosen topic traction, which is then incrementally built upon by the contributions from other participants and made the focus of the conversation. Appendix 2 illustrates how turn taking was organised in a way that constrained the conversation to topics nominated by the chair. Turn taking not only empowered the chair to sustain her topic of interest, it also shut down other topics and the opportunity for multi-ontology sense making. In Appendix 2 the topic, 'language of cancer', is treated as a distraction from the network's core business, 'the project goals', and is shut down (lines 43-44). Based on the detailed analysis of turn taking undertaken, the institutional talk of the network could be described as chair-centric with an emphasis on management issues. Typically the topics nominated by the chair were oriented towards the organisational aspects of managing the network, such as goal setting or the technical aspects of cancer care, such as care protocols. While these practices of chairs have been noted by others, [18,21] our concern is its implications for multi-ontology sense making. Typically, management issues were discussed at the expense of 'right brain' [3] relational issues relating to the human and aesthetic challenges faced by patients and clinicians, such as the vulnerability of patients with complex cancers receiving radiotherapy.

Skilful relating

Although managerial discourse-in-practice, and the relationally oriented discourse-in-practice, had a different focus, both kinds of talk were hybrids of factual, expert and narrative talk (Table 3). The presence of narrative talk as well as factual and expert talk, regardless of the issue, indicated that the network had the linguistic resources to construct conversational spaces that supported multi-ontology sense making and narrative rich conversations.

This was in contrast to other networks in the study where the lack of narrative talk limited the opportunities for multi-ontology sense making. In Appendix 2 we see an absence of relationally oriented discursive practices because the chair's managerially oriented discourse-in-practice prioritised meeting their requirement to complete the project as the main task they had been given, 'Yep, so this is what we've got. I don't really care how we come out at the end of it. As long as we actually get there' (Appendix 2, lines 85-86). Rather than dealing with the tension that existed among the sub-committee members around the purpose and original intent of the sub-committee and why the members had

Table 3: Examples of factual, expert and narrative talk

TYPE OF TALK	SPEAKER	EXTRACT FROM MEETING CONVERSATION
Factual	Chair	For our project itself, we kind of need three goals out of it. We need a short term, a medium term and a long term goal. And the time frames for those, we've got about 18 months to achieve the long term goal.
Expert	Chair	Thank you. You sent me some very interesting journal articles, and some of those really looked at the fact that the majority of follow-up care is purely psychosocial. That most people don't find a reoccurrence at a follow-up appointment and that basically they are just going. And the people affected by it are anxious up to the appointment, and then greatly relieved after the appointment. So it actually forms a psycho-social function. And I've got that paper here.
Narrative (experience)	P4	Cos, I have had conversations with various cancer care coordinators. And what people are saying to me, that patients having radiation therapy. When they're finished, particularly rural patients when they are discharged back to their local area these local cancer care coordinators have no way, of picking them up, we have no idea how they are going.
Narrative (technical)	P1	It's got when their next appointment is. It's got their admission date, why they were actually admitted.
	P2	It's like a hand held record.
	P1	It's got notes. It's got who their consultant is, what treatment they're having. It's fantastic. It's got a list of expected side effects.
	Chair	Did people use it?
	P1	Yes, we wouldn't do without it. Patients have to use it. We write their blood counts, everything in it.

chosen to participate, the chair was already opting for a rigid social ordering: 'Yeah, well, I am just a bit flummoxed. This doesn't seem to be consistent with anything that I can remember' (Appendix 2, lines 74-75). Single ontology sense making, that favoured the known and emphasised the technical and scientific as the resource for decision-making, therefore prevailed.

However, although narrative was an overall feature of talk around both types of issues, it was narrative with a technical theme that typically dominated managerial discourse-in-practice. In contrast, relationally oriented discourse-in-practice was typically dominated by narrative with an experience theme. Narrative with a technical theme was constructed using factual language and described the 'workings' of cancer services, such as the systems for referring patients to cancer services. Technical narratives made no reference to the experience of anyone involved. Therefore, despite having a narrative element, managerial discourse-in-practice focused on technical detail and was indicative of single ontology sense making, heavily oriented towards fact and expert opinion and entitative ways of thinking.

In contrast, relationally oriented discourse-in-practice around cancer care was characterised by narrative with an experience theme which often described tragic experiences that can invite feelings of compassion and empathy in the listener. [22] Experience narrative therefore has the potential to orient the listener to 'right brain' issues relating to patient or clinician experience. Relationally oriented discourse-in-practice was more reflective of multi-ontology sense making where expert, fact and technical and experience narrative were all intermingled. By accommodating experience narrative, the network was no longer restricted to working with verifiable information on the technical and scientific aspects of cancer care. Rather, clinician and patient experience, a linguistic resource not typically accommodated in the dominant entitative discourse of healthcare, [2,4,8] was instantiated into the decision-making process. However, despite having the opening to use these linguistic resources, the opportunity for multi-ontology sense making to be maintained and sustained was limited in practice and relationally oriented talk was most often shut down by managerial discourse-in-practice. Consequently, since relationally oriented talk (which was inclusive of experience narrative) was the avenue for multi-ontology sense making, the potential of a multi-perspective approach to decision-making was not realised in the meeting conversation of the network.

Discussion

Management decision-making in healthcare draws upon a number of forms of evidence: information/data from within the organisation, best practice reports, research studies, information from experts, stakeholder preferences and experience, [23] reflecting the linguistic capability in healthcare contexts for multi-ontology sense making. However, despite the full range of linguistic resources being available to the network in this study, and hence the opportunity for multi-ontology sense making, they typically reverted to single ontology conversations, by adopting evidence-based rational decision-making. Closing down relationally oriented discourse-in-practice was a lost opportunity that had implications for the network. There were brief instances where relationally oriented issues were also considered and multi-ontology sense making was emerging e.g. the sub-committee's brief discussion around changing the language of cancer so that the focus is not solely on the treatment phase but good health in the longer term, and the role of the network in the culture change. However, since multi-ontology sense making was unable to take hold the sub-committee missed an opportunity to potentially re-frame their dilemma from being about communication tools and information for health professional to adopting the more innovative and ambitious path for their project to, 'embed [survivorship] in the culture of [cancer] treatment' (Appendix 1, line 36).

Further consideration of these instances revealed that the institutionality of the network's talk had implications that were not previously evident. The notion of conjectural talk emerged as an important point of difference between single ontology and multi-ontology sense making. Conjectural talk was noticed when relationally oriented issues surfaced and were incorporated into professional sense making generating a 'dilemma rich' conversation. By contrast, single ontology sense making was 'dilemma poor' (as illustrated in Table 3), as little attempt was made to understand the relationally oriented aspects of cancer care; and if human/social issues were raised, they were acknowledged but not incorporated into professional sense making. Dilemma rich conversations emerged as conversational spaces that held the possibility for different opinions in the form of experience narrative to emerge and conjectural talk unfold. Conjectural talk was a discourse-in-practice through which new ideas could develop and was a catalyst for multi-ontology sense making. Unfortunately, however, the institutionality of the network's talk constrained conjectural talk and routinely shut down multi-ontology sense making. No one knew or

tried to change the conversation so that conjectural talk could become the discourse-in-practice but the mere fact that it had emerged suggested that there were unrealised possibilities that could be skilfully developed.

The network's underlying preference for 'left brain' [3] or technical, scientific issues, as revealed by the chair's orientation towards management issues, did not allow the human and social aspects of cancer care to be developed as a source for creative and innovative solutions. Given the network's complex brief, which was to enhance collaboration, their single ontology approach to decision-making can be rendered less skilful than the multi-ontology approach that they consistently shied away from. Single ontology sense making reflects more rigid social ordering and is considered less skilful in this context because it renders it unnecessary to deal with difficult organisational dilemmas through multi-ontology sense making.

Leaders can enable conversations in which participants engage actively in conversations where differences of opinion are accepted as a critical part of decision-making. When sense making is skilfully handled, it starts to create a flexible social ordering, which has creative tensions and potentials, and where the status quo, if necessary, can be nudged in a different direction. Skilful relating is therefore likely to emerge in a network where there are relationally aware and attuned members who are able to re-contextualise so that single and multi-ontology sense making are understood and the relevant processes of decision-making are enacted. This is a tall order in many healthcare contexts, however, in their absence, sense making will favour the technical and scientific as the resource for decision-making and the opportunity for creative innovative solutions is routinely lost.

Relational leadership is essentially about creating dilemma rich environments, which feels ambiguous and unclear to those involved. A dilemma rich environment is evidence of the presence of skilful relating amongst the membership of a network and the leadership that emerges is hard to predict. In contexts which are dilemma poor, single ontology sense making gives the illusion that things are straightforward and not messy, [10] thereby negating the need for skilful relating and any talk about relational leadership would likely fall on deaf ears. Leadership in such contexts is easier to identify, predict and perform. [21]

Conjectural talk is an important enabler of skilful relating because it is the discourse-in-practice that most likely changes sense making so that disorder is sustained and

of course, is not a comfortable place to be for many professionals. Leaders are skilful in that they work towards and gain cognitive acceptance of the values and virtue of entertaining disorder by those involved in decision-making. However, in instances where leaders fail to achieve this, conjectural talk is smothered by managerial discursive practices and the opportunity for skilful relating is lost for however long it takes for a competing discourse to take hold. In highly professionalised sense making environments, even those which are dilemma rich, skilful relating is unlikely to emerge if leaders cannot work out how to reframe institutional talk to achieve cognitive acceptance of a relationally framed discourse and ultimately, multi-ontology sense making.

The resources that leaders use to exert influence are broader than linguistic practices. [10] Therefore a limitation of this study was the use of video-recordings of meeting conversations as the single source of empirical material. Although empirically significant, the material presented provides a partial understanding of the resources available for professional sense making. Qualitative techniques such as ethnography are therefore suggested for further studies.

The empirical examples of skilful relating described highlight to health professionals the importance of challenging single ontology sense making when dealing with difficult organisational dilemmas. This paper provides practical examples of multi-ontology sense making that could lead to creative and innovative solutions. This study provides new empirical material showing skilful relating as leadership practice and the implications for decision-making when it is only partially and intermittently achieved.

Conclusion

Skilful relating can change the course of decision-making. The absence of skillful relating can affect how professionals deal with dilemmas in a network. There is reluctance amongst those who uphold managerial discursive practices to consider anything other than the 'known' as a resource for their decision-making. While relationally oriented discursive practices, such as the sharing of clinician and patient narratives about care can be a part of professional sense making, they are not always developed and relationally-oriented discourse-in-practice become hard to sustain. Skillful relating reflects the careful handling of these opposing perspectives, and if realised, can lead to multi-ontology sense making and flexible social ordering. By creating a conversational space where all perspectives are given a voice and heard, conjecturing about what could be

can take hold and a myriad of possibilities explored. Skillful relating also has a role in sustaining creative thinking. Dealing with the cognitive, social, political and emotional processes of decision-making is the means through which leadership works to encourage long-term commitment to new courses of action through re-contextualising the decision-making task. Relational leadership does not anoint a leader but challenges us all to think relationally and act responsibly in creating flexible social ordering that allows for multi-ontology sense making.

Competing interests

The authors declare that they have no competing interests.

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Appendix 1: Extract of meeting conversation showing how management oriented discursive practices support and sustain single-ontology sensemaking.

LINE NUMBER	SPEAKER	MEETING CONVERSATION
1 2 3	Chair	I wondered about focussing on health after treatment, it gives it a new language, it gives a patient focus. I read this really interesting article about how we use language around cancer that is all about war, fight and . . .
4	P2	Yes, fight the battle.
5	Chair	Desperation.
6 7	P4	You know, I had a patient say to me. She said, 'you know, I have read about all this battle with cancer, I'm waiting for the battle'.
8	Chair	Yes.
9	P2	You know,
10 11	Chair	They kind of feel slack if they are not in their factices. As opposed to being fatigued [laughing].
12	P3	Yes, I heard similar to that. I like cancer with a little c.
13 14 15 16 17 18	Chair	Exactly. So that's where I thought maybe we needed to change the language, make it about good health. And I was thinking it should just be after treatment. I think that maybe that is something we can think about. With them saying yesterday that you should think about health and well-being at point of diagnosis, do we talk about being in good health then? Right at the start, is that what we do?
19 20 21	P2	I couldn't agree more. Work towards being healthy after treatment, from the beginning.
22	Chair	Yes.
23	P2	Because . . .
24	Chair	Being healthy.
25 26 27 28 29	P2	That's exactly it, being healthy after treatment. Because people go through the treatment, all the modalities, with an incredible amount of support, as an in-patient or out-patient. And then at the end of treatment it is a really difficult thing, for them to move on. They feel like they have been forgotten about.
30 31 32	Chair	And the research supports that strongly. They say that up to three months after active treatment they fall in a complete hole, and they just don't get enough support.
33	P2	Yes, we should start, talking about being healthy.
34	Chair	Exactly.
35	P2	Working towards it.
36	Chair	Embed it in the culture of the treatment.
37	P2	Yes.
38	Chair	That's a big goal.
39	P2	It's huge.
40	Chair	I know.
41 42	P3	It's a change for the mindset for people. You know it's got to start somewhere.
43 44	Chair	Oh, all right. Coming back to our need for three goals, short term, medium, long term.

Appendix 2: An extract of meeting conversation showing the absence of relationally oriented discursive practices leading to an entitatively-driven discourse-in-practice.

LINE NUMBER	SPEAKER	MEETING CONVERSATION
1 2 3 4 5	Chair	OK. Let's get this meeting crack'n. We have a couple of girls from the Gold Coast coming, so they will be here soon, hopefully. But, umm, from the meeting we had at the hospital, we have three different groups. Some of us are involved in a couple of groups. And, like me, thank god I am only involved in one.
6 7 8 9 10 11 12		So we have communication. So basically, we have got to think like Care Coordinators and that's what our focal point will be. So when we actually look at patient admission to our service, or discharge from our service it's not like discharge from hospital. What we want, you know, how we want patients to come in to our service. What sort of criteria are we looking at? What sort of, I suppose some sort of, formal type barriers we are looking at.
13 14 15 16		I have just done some quick things to identify some main objectives and stuff like that to help this meeting. I have also drawn up some barriers. Resistance to change, team role and all that sort of stuff, so hopefully we can get the ball rolling.
17		[S1 puts up her hand]
18		Yes dear.
19 20	S1	Can we just move back a step? [Laughing] I'm a little confused because this doesn't resemble…
21	Chair	What I have just said?
22 23 24	S1	No, no, no. It doesn't seem congruent with what we were discussing our projects were going to be about at the end of that workshop. Is this what's come out of that?
25	Chair	Yep, we had a meeting about 2 weeks ago where we.
26	S1	[interrupts] Who's we?
27	Chair	All the chairs that were chosen for the three groups.
28	S1	Okay
29 30 31 32 33 34 35	Chair	And everybody turned up and this is basically what came out of it. What I actually emailed off to you about communication. That was that thing. I was also dumb struck. I thought we were discussing something different but apparently there is some sort of electronic database that is going to come into existence very soon. All electronic data recording and all that sort of thing. So all we are looking at is basically, we are looking at it from our service.
36	S1	So what happened to all of our research projects?
37	B1	Yeh . . .
38	S1	Cos, that's what we thought this was about.
39 40	B1	From that workshop. There were four presentations and three were chosen as the priority, of which . . .
41	S1	Yes.

Appendix 2: An extract of meeting conversation showing the absence of relationally oriented discursive practices leading to an entitatively-driven discourse-in-practice *continued*

LINE NUMBER	SPEAKER	MEETING CONVERSATION
42 43 44 45 46 47 48 49 50 51 52 53 54 55 56	B1	This was one of them. So what I, I'm not sure, I'm not sure if I sent that through to you. This was the summary of the communication project . . . [Passes paper to S1] . . . that was presented at the cancer care coordinators workshop in June. So from there, people nominated what groups they were going to be involved in. So from there, got together with D, who sort of went through the nominations for the group and elected people. And here you are. So, this part here is just a guide. You know, that for any project you have got to have your purpose, your goal, your scope. What you want to do, what you want to achieve, those sorts of things. So this is just a bit of a guide. This is just examples, not necessarily to do with your particular project, it is just what they want you to direct. So this group has to decide what they want to achieve from the actual, out of the project itself. *6 seconds silence*
57	S1	I can't actually remember what it was we were doing.
58	Chair	This is what we wanted to do.
59	S1	But this doesn't seem to resemble it.
60 61 62 63 64 65	Chair	No, I think the communication has been overlooked. I actually spoke about communication. One was about how to communicate with ourselves effectively, like how do we communicate with each other. But also how do we establish better forms of communication with allied health, with other medical services, like x-ray departments and that sort of thing. So out of all that has apparently come this. *4 seconds silence*
66	S1	Right
67 68 69	Chair	And we can, and this is all I know basically. That we have been given. And we chatted about what she was looking for, so the objectives we got were the ones here that I emailed out to you.
70 71 72	S1	So that's all for you. [Reading papers for 4 seconds] Have we got the originals? Cos I am completely lost to be honest.
73	Chair	That is all I have got.
74 75	S1	Yell, well, I am just a bit flumaxed. This doesn't seem to be consistent with anything that I can remember.
76	Chair	This is all I've got.
77	B1	That is actually what was presented. That little sheet document.
78	S1	Is it? 5 seconds silence
79 80	B1	In relation to the communication. The two other projects that were presented.
81	F1	These were those dot things.
82 83	B1	Yep. So the two other projects are the Care Coordination Referrals Project and the Putting Faces to Names.
84	S1	Yep, well, I must be just developing Alzheimer or something. [Laughing]
85 86	Chair	Yep, so this is what we've got. I don't really care how we come out at the end of it. As long as we actually get there.

Appendix 2: An extract of meeting conversation showing the absence of relationally oriented discursive practices leading to an entitatively-driven discourse-in-practice *continued*

LINE NUMBER	SPEAKER	MEETING CONVERSATION
87	S1	Mmm. Mmm. Okay
88	Chair	I will just treat this like I do when I am orienteering. I don't care how I get from A to B, as long as I get there. [laughing]
90 91	S1	[Laughing] Okay, you just have to specify what B is for us. What are we actually going to be doing?

On the Use/Misuse of Health Research Gatekeeping Powers in Australia: an under-considered problem?

P Murgatroyd, L Karimi, P Robinson and J Rada

Abstract

Significant investments have been made internationally, including in Australia, to enhance evidence generation and implementation in healthcare. Nevertheless, large knowledge gaps persist, and changes in clinical settings are slow to appear. This impacts service efficiency and efficacy, and ultimately the health and wellbeing of individuals and communities.

However, despite this situation, surprisingly negative attitudes to research exist within healthcare. This paper describes a number of cases where research has been blocked at various levels by Australian health organisations, managers and clinicians for reasons of corporate and individual self-interest, rather than ethical or resource-related concerns. We call this tendency nimbyism in healthcare research and suggest it often operates through the misuse of gatekeeping powers at the nexus between potential research participants and would-be researchers. We identify three levels where research nimbyism can operate: 1) institutional control of research activities 2) dissemination of findings 3) vested interests of individuals in the status quo. We propose that nimbyism may not be an unusual phenomenon.

Ethical aspects of research gatekeeping, including societal and individual aspects, are considered together with possible motivations. We ask whether patterned, covert and unauthorised misuse of gatekeeping powers is an under-considered problem affecting evidence-based practice and the right to research participation and call for more research into this phenomenon.

Abbreviations: EBP – Evidence-Based Practice;
HEC – Human Ethics Committee.

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Introduction

The need to build research capacity and evidence-based practice (EBP) has become something of a mantra in public health services and health practitioner education, but implementing change in clinical practice is a complex and ongoing process. [1] This paper addresses a potentially under-considered obstacle in the EBP field, which we refer to as nimbyism in healthcare research.

The term 'nimby' is an acronym for 'Not In My Back Yard'. [2] It was first used in 1980 and commonly refers to the tendency of residents to oppose new developments in their own neighbourhood. The implication is that often, while such individuals agree that these developments are socially desirable, they want them to be located further from their own homes. People adopting such stances are sometimes referred to as 'nimbies'.

Is it possible that some healthcare managers, clinicians and funders take a similar view of scientific research and its application, and work to avoid it in their areas of practice? Surprisingly perhaps, anti-research attitudes may well be far more prevalent in healthcare than one might imagine. In our many years of research endeavours in Australia, the authors and other colleagues have repeatedly encountered situations, where clinicians, health managers and organisations support EBP in public, but oppose the collection of evidence and implementation of evidence-based findings within their home practice. This reluctance to allow research into their service appeared to grow stronger if there was a perception that the research would truly question embedded clinical routine and habits, and where the results might potentially require a rethinking of common practice. In all the cases we have experienced, the motivations for blocking research seemed primarily related to narrowly defined self-interest, rather than genuine ethical or resource-related concern.

Nimbyism as gatekeeping

The theory of gatekeeping originated in the 1940s and was primarily developed from the work of Kurt Lewin in his analysis of how editors selected news items. [3,4] Since then it has been applied to many fields, including healthcare.

We argue that the concept of nimbyism in healthcare incorporates several levels of gatekeeping. The first level includes the institutional control of social or scientific research. The next level deals with publication or dissemination of research findings. The final level involves the vested interests of individual managers and clinicians in maintaining the status quo. All three levels can be interpreted as various types of gatekeeping.

Mosby's *Medical Dictionary* defines a gatekeeper in our sector as a healthcare professional, usually a primary care provider, 'who is the patient's first contact with the healthcare system and triages the patient's further access to the system'. [5] Gatekeeping of both treatment and information in healthcare is a common phenomenon - examples include receptionists who protect GPs from too many appointments and operating room nurses who control information flow in clinical practice. [6]

Gatekeeping in healthcare research, as opposed to treatment, has been defined as the process of allowing or denying access to a selected research site. [7] Gatekeepers in research have been described as those who have the power to refuse researchers access to their chosen sample population or have the power to influence others. [8]

According to our analysis, research gatekeeping involves having discretionary control over at least three potential access channels: a) the access of would-be researchers to involve participants in their projects; b) the access of service users to informed opportunities to participate in research; c) the access of society and individuals to useful knowledge about healthcare effectiveness and efficiency.

While many consider any type of gatekeeping at all as a negative behaviour, in some circumstances it is useful and even important. For example, access to a particular research site or a specific population group can present significant ethical issues requiring special considerations before approach. Gatekeepers are and should be able to advocate for and protect vulnerable people; and of course, much of this thinking has evolved since World War II and the Nuremburg conventions.

There is little discussion in healthcare literature concerning the problem of the misuse of research gatekeeping powers. Lee cites some relevant examples of 'unofficial gatekeeping', although her paper focuses on guarding access to potentially vulnerable people. [7] Albutt and Masters [9] describe how they encountered multiple levels of gatekeeping and outright refusal when trying to do research with users of mental health services. Sharkey et al [10] use the expression 'clinician gatekeeping' to refer to decisions by clinicians to exclude individual participants, or groups of participants, from research for reasons unconnected with the project's eligibility criteria (for example a clinician may think a patient is too busy).

In the present paper we discuss a number of cases of gatekeeping and discretionary control over research-related access channels in the Australian context. It is significant that the obstacles described here seem very different to most of the discussions of research gatekeeping in the literature, in that they were unconnected with participant wellbeing, and mainly based on considerations such as status, personal convenience or corporate self-interest. When we first encountered health research blocking, we assumed they were isolated instances. However, over time, we have found it to be such a common phenomenon that we now regard it as a necessary consideration in the preparation of any proposed project by us as would-be health researchers.

Health research nimbyism is difficult to research formally, since by its very nature it works to stifle research activity before it can occur and little public record of it exists. All four authors are quantitative researchers by training, and would prefer to be able to provide robust evidence concerning the behaviours we identify in this paper. After all, individual

experiences are easy to dismiss as anecdote and conclusions based on them are often rejected as inconsequential. However, the consistency and frequency of our encounters with research nimbyism suggest that there is a real problem with anti-research behaviours in healthcare, and that this problem deserves more serious discussion than it has received to date.

Institutional control of health research

The first level where research nimbyism can take effect is via the institutional control of health research through such means as conditions of entry, defining the problem of study, access to data and respondents, funding, and scope of analysis. The need to review research projects to ensure they are ethically and methodologically sound is well established. But on occasion these imperatives metamorphose to achieve a very different effect, and the reasons given for blocking research can appear to be a pretext masking other, less laudable motivations. For example, access may be blocked to groups perfectly able to speak for themselves on the grounds of vulnerability or the need for privacy protection. [9]

We have experienced comparable cases where the power to scrutinise research methodology was used to block an inconvenient research proposal on two separate occasions. The aim of the project was to carry out a qualitative exploration of reflections by clinical staff concerning practice errors, many of which would not have been recorded, as these are not always recognised as errors until well after they have occurred. Discussions with colleagues (and not always close ones) indicated considerable enthusiasm for such a project, the outcomes of which would have included recognition of warning signs for these events. A proposal was written and peer reviewed (with the comment 'This is amongst the best proposals I have ever read' from an independent reviewer) and submitted to the Human Ethics Committee (HEC) of a large urban health network, where it met with a large group of nimbies. The proposed qualitative method was deemed unethical, the HEC chair took it home for his wife to read ('because she is a nurse and will understand it and have relevant comments') despite the fact that HEC applications are supposed to be confidential. The project was refused permission from the HEC to proceed and went to the back burner.

At the time, the fact that someone not appointed to the HEC was consulted in such a way felt like an astonishing but isolated phenomenon. Today we consider that it was part of a deliberate process to ensure that the project did not see the light of day in that network – gatekeeping of the 'lock and throw away the key' variety. Several years later the project was revived in a second network with a similar outcome; this time the proposal did not even make it to the HEC and was blocked after the network made preliminary approaches to a hospital legal department. Without seeing the protocol, the legal team provided 'under no circumstances' feedback due to concerns about litigation (although this would have been impossible as the protocol required that the incidents had not been recorded in clinical notes at the time and had occurred some time ago).

Publication and dissemination of research

The second level where nimbyism can influence evidence generation is the publication and/or dissemination of research. The problem of the suppression of health research at the government level in Australia is not new, especially affecting service evaluations with negative results, [11,12] and there is evidence of publication bias in Australia against research with negative or inconclusive results. [13] Similarly it is known that commercial entities influence research results in various ways. For example private sponsorship of research is statistically associated with published outcomes favourable to the funder, and confidentiality clauses are used to conceal unfavourable results. [14] However, the extent of the problem of publication suppression across the full range of players in the nation's health landscape, for example including networks and individuals, remains uninvestigated. Similarly, there has been no clear and systematic attempt to redress this.

One of the authors was involved in research which was completed, but whose findings have never seen the light of day. A large organisation in a major Australian city was evaluating a specific federal hospital program, addressing a disease listed in the current National Health Priority Areas. The research was to verify that current activities met the relevant regulatory criteria, in order to assure continued funding. Once the preliminary results were available, showing gross underperformance in both management structure and health outcomes, it seemed obvious that major changes would be needed in order to satisfy the official program criteria. Instead of exploring solutions to the problem, permission to access further data was denied and appointments with key people in the organisation cancelled.

The organisation had set up the current 'system' many years previously, well before any criteria for success were determined. The individuals concerned felt very comfortable with a system that was easy to run and manage, even though there was little evidence of success as defined

by the state health department. The researcher discovered that similar findings had been previously produced by at least two other researchers and their documents shelved. Needless to say, the research findings in question were never used, acknowledged, or further discussed. There may be many reasons why the research findings were rejected and suppressed, but there seemed to be three major factors involved:

- the organisational leaders were not visible champions of required change;
- people were not sure how the changes would affect their jobs and what new expectations they would have to deal with;
- people's concerns (within the organisation) with the necessary changes were not addressed.

Vested interests of individuals

The third level of research control incorporates the power of individual managers and clinicians to control the nexus between would-be researchers and potential participants. This is particularly important given that managerial approval is needed for any research proposal and the cooperation of clinicians is usually required to collect data in the absence of specially funded researchers.

Sometimes the blocking of research projects at this level has taken public and active forms. In an extreme example, a senior manager in one of the country's leading health networks publicly over-rode clinicians in the service and other stakeholders to veto a trial of a novel clinical outcome measure. Previously the manager of a community rehabilitation service in the same large Australian city had also declined to allow it to be trialled in another service. Neither manager offered any justification for their decision, such as methodological grounds or resource limitations (and of course we fully understand that limited resources can be good reason to not participate in research). These management refusals were even more surprising and disappointing, in that there are large evidence gaps in these clinical specialities, as in so many others, and it might be expected that these clinical leaders would actually be keen to expand the knowledge base.

More commonly, however, individual resistance to taking part in research has taken the form of a sustained absence of communication or cooperation rather than outright refusal. Not answering emails or phone calls is a particularly frequent response when a nimby clinician is approached with a request to take part in a research project. It seems that for reasons that are never disclosed, they don't want to say yes, but they don't want to be publically seen to say no

either - so the best approach is simply to ignore it. In one of the authors' first encounter with this phenomenon, a team of seven community occupational therapists used this method to avoid participating in a project to research the outcome of referrals from hospital wards to their service, despite the completion of a successful pilot project as well as the very limited evidence in this clinical field in the peer-reviewed literature.

One of the problems in Australia is that for clinicians and managers, participating in research is often seen as a matter of personal choice, rather than a professional obligation. In our own experience, the success rate in recruiting clinical staff, allied health therapists and managers to research projects is less than 50 per cent. Refusal and non-cooperation blocked three of one of the author's projects in three years, while the sample in the one successful project was halved due to non-cooperation. The take-home message from experiences like these is inescapable (and probably unprintable), particularly as there have been considerable additional personal costs. The protracted waiting, frustration, broken promises, contempt and rudeness inevitably make one consider whether trying to undertake rigorous research is worth the trouble.

Motivation, ethics and effects

In public, health research nimbies subscribe to the official discourses about the need for evidence generation and utilisation in healthcare, but in practice do not support such efforts. Why is this so? Most research nimbies are anything but clear about why they oppose a project on their turf. We do not believe that a lack of education is a major factor, whether for managers or clinicians, given that under- and post-graduate education generally covers EBP and research methodology in some depth. Similarly, we have seen no evidence of ethical or resource-related concerns.

In fact, the most common nimby motivation seemed to be that the research could demonstrate clinical under-performance. We have seen this motivation in individual clinicians as well as managers, seemingly wanting to safeguard the status of 'their' service. It is an unethical, perverse and disappointing view, which transforms the potential power of research to generate new information for improving practice into a personal inconvenience and threat.

Other plausible motivations include a sense of personal power and control, a need to be considered expert in a particular body of knowledge, limited understanding of the accumulative nature of scientific evidence building, personal insecurity, convenience, conservatism, and conformism.

Whatever the specifics, in essence this is another variant on the agency problem, usually seen as mainly afflicting sections of the medical profession, but no doubt much more widespread in healthcare. Agency-based analyses suggest that due to the very nature of their roles, health managers and clinicians represent the interests of two parties – on the one hand the public, and on the other themselves. [15] When a clash emerges between these two interests, some clinicians and managers favour themselves.

Research nimbyism driven by a desire to protect clinical activities from scrutiny seems closely related to the culture of corporate secrecy revealed in the recent investigations into systematic malpractice and cover-ups in parts of the United Kingdom's National Health Service, which resulted in hundreds of unnecessary deaths. [16] Also relevant in this respect is public anger at the betrayal of trust by the individuals and organisations concerned.

Michael Lipsky's concept of street-level bureaucrats provides another useful perspective for understanding these behaviours. [17,18] Lipsky used the term street-level bureaucrats to describe officials such as police officers, social workers and teachers, who are at the interface between the state and the public. In brief, Lipsky's analysis suggested that regardless of official discourses, bureaucrats (i.e. clinicians/ managers) often have discretion over how they carry out their roles (e.g. regarding evidence generation). They may use this discretion in authorised or unauthorised ways. Their use of discretion becomes, in effect, policy, and systematic informal patterns in the way bureaucrats use discretion are significant.

Applying Lipsky's analysis, the anti-research actions of clinicians-as-street-level-bureaucrats not only run contrary to official pro-EBP policy, they in effect constitute a parallel unsanctioned policy. As mentioned above, the aims pursued by this private parallel policy seem diverse, but regardless of divergent motivations, the effect is similar. Through their actions, these individuals and organisations create blockages in society's access channels to healthcare-related evidence, and the access of citizens to opportunities to take part in research. Indeed, as Lipsky pointed out, patterns of practice can be functional for individuals or organisations, but dysfunctional in terms of overall policy aims. Perhaps therefore, the best descriptor for these individuals is street-level gatekeeper.[1]

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[1] In the course of writing the article, we have been tempted by several alternatives including 'Not on My Ward Ever – NOMWE (pronounced gnome)', 'Scared of Research In to My Practice (SCRIMPite)', and 'Anti-Research Street Level Bureaucrat (ARSLeB)'.

Clearly, research nimbyism raises serious questions about the professional ethics of those who practise it. For instance, many of these gatekeepers are self-appointed, have no special training in research (let alone research ethics) and are completely unaccountable for their actions. There is no requirement for them to justify a rationale for their decisions. No record is kept of the number or type of blocked projects, and there are no consequences for not taking part in research.

Sharkey et al, [10] basing themselves on the case of well-intended but misguided clinician decisions to exclude research participants, argue that even this well-intentioned clinician gatekeeping violates the basic principles of international ethical guidelines: respect for patients, positive balance of risks and potential benefits, and honest distribution of the benefits and burdens of research. According to Emanuel et al, fair selection of research subjects is an ethical necessity in scientific research. [19] However, health research nimbies who exclude certain population groups in bad faith do not just ignore ethical guidelines. In fact, they work to achieve diametrically opposite results to those pursed by research ethics. For instance, by definition, in these cases service users are not asked to provide consent to not participate in research – instead, the decision that individuals and groups will not participate in research is taken for them, and what is more the fact that a decision has been made at all is kept hidden and unjustified. Of course some nimby activity may represent a form of paternalism, possibly with no ill intent intended, but ultimately unhelpful nonetheless. However, given the removal of autonomy and informed choice, it could also be argued that it is no exaggeration to consider nimbyism analogous to coercion.

Additionally, by removing 'their' patients from projects, nimbies introduce selection bias, potentially affecting the generalisability of results. Reducing sample sizes also reduces statistical power, which in turn impacts on the quality of results and brings with it the risk of false negatives among other things. [10] From this perspective therefore, nimbyism works against the fundamental aims of health research such as improved health, truth, knowledge and avoidance of error. [20] From the societal perspective, it not only blocks access to quality information, but also ensures that scarce funding resources allocated to EBP do not achieve their full potential.

In terms of fairly distributing benefits and burdens of research activity, nimbies perpetuate the burden of unevidenced or under-evidenced clinical activities, and exclude people from access to the potential benefits of

research in the form of improved effectiveness. This is not just a matter of theoretical interest, but represents the misallocation of shrinking resources, avoidable and unnecessary suffering, unrealised potential and in some cases even death. It could be argued that deliberately and consciously deciding to not allow people to participate in public health research for purely personal reasons is only a few steps removed from deliberately and consciously providing suboptimal treatment in the future. Arguably this is a form of professional malpractice. The ethically and morally repugnant aspect of health research nimbyism is perhaps one of the reasons why passive and covert non-cooperation is usually the preferred method. Strategies to avoid gatekeeping such as developing projects in partnership between clinicians and professional researchers are proposed in Sharkey et al [10] and Yazahmeidi and Holman. [11]

Taking a wider perspective, we cannot avoid wondering whether unofficial but patterned research nimbyism merits closer examination as a factor in the well-known difficulties in gathering health research evidence. Some of the current approaches to improving knowledge generation, including education opportunities, conference participation, and making more research resources available, are based on the assumption that organisations, clinicians and managers actually want to build and implement evidence, but simply lack the necessary skills and tools. If this assumed goodwill did not exist in a given area, then these approaches would deliver limited results and perhaps other means would need to be considered to complete potentially controversial research into service outcomes. It is hard to think of another industry, where it would be considered reasonable to expect managers and workers to help reveal what may be a dismal failure to perform in key target areas, with potentially serious consequences for themselves. A more usual approach is for reviews to be completed by external consultants.

Conclusion

There are indications that various health service insiders (clinicians, managers and networks as a whole) sometimes prevent research into their activities for various reasons. For instance, gatekeepers may deliberately limit clinical research in order to protect vulnerable patients or their families. Clearly, would-be researchers have to be able to demonstrate that their projects are necessary, credible and ethically appropriate, and that the researchers are competent. Gatekeepers need to have sufficient information to enable them to make sound decisions and projects need to have adequate resources.

However, the cases of health research nimbyism discussed in this paper were grounded in a very different set of considerations related primarily to corporate and individual self-interest, and in particular a fear that the proposed research could reveal clinical underperformance.

The misuse of research gatekeeping powers can have serious ethical implications for interactions between providers and patients. It places a number of basic principles of health ethics at risk, in particular beneficence, non-maleficence, respect for persons or autonomy and justice. Appropriate and effective clinical research not only strengthens the good and contributes to a favourable balance between benefits, risks and potential harm (beneficence). It also helps avoid doing harm (non-maleficence), for example by contributing to the appropriate use of new treatment approaches and avoiding the misallocation of scarce resources. Justice requires an equitable distribution of the benefits and burdens of research participation across individuals and groups, while autonomy means giving service users informed choices in whether or not to participate in research. [10] The misuse of health research gatekeeping powers works in a diametrically opposed direction to all these principles. By limiting knowledge, the ultimate effect of research nimbyism is to deprive both individuals and populations of potential improvements in health.

Of course, not all Australian health managers and clinicians are of the nimby variety, and many are keen to participate in well-designed and executed research. As noted above, something less than 50 per cent of the clinicians and managers we have encountered were happy to be involved in our proposed projects. No doubt, the extent of the problem varies across cultures and professions, in Australia and elsewhere. The diffuse and concealed nature of this resistance to health research means it is hard to quantify its extent and broader impact, but it has certainly not been an isolated phenomenon in our research endeavours. In summary, we suggest that health research nimbyism in Australia is a real and under-considered problem deserving further examination as a factor blocking the generation of quality health-related evidence. We believe formal research into researchers' experiences and public opinions of nimbyism is long overdue.

Competing interests

The authors declare that they have no competing interests.

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EDITOR'S NOTE

This third issue of 2015 reflects a first for the APJHM: the creation of our first Special Issue. This concept was the result of the initiative by our editorial staff and in particular our assistant editors. Our appreciation to Gary Day and Gian Luca Casali in agreeing to edit this issue and for bringing together a range of contributions to the Special Issue. They have also provided its editorial content.

The introduction of the concept of a Special Issue also coincided with increased interest from authors submitting articles for publication. In fact we have experienced a doubling in the number of articles being processed by the Journal and we of course appreciate this level of interest. It did provide a dilemma in terms of how many issues we might produce and how best to consider 'special issues'. Our collective wisdom is that we should continue to publish three issues each year and have the option for a Special Issue annually. So one issue a year will be presented in a similar format to this one - a Special Issue that includes a general supplement.

The other point I need to emphasise about the publication of the APJHM is that all the editorial and production staff are part-time and many provide their services in an honorary capacity, as do many College members, who willingly act as peer reviewers for the Journal. So as a team of part-timers we respond as best we can to author submissions, which as described, are continuous, constant and increasing.

Our part-time team is also undergoing some change with the transfer of the Production Manager role from Carolyn Marsh to the ACHSM Librarian, David Burt. Carolyn Marsh has been involved in the Journal since its inception whilst the Executive Officer at ACHSM and subsequently became production manager until recent times. We would like to take this opportunity to thank Carolyn for her contributions since the Journal's commencement in 2006; at the same time acknowledging and welcoming the contribution that David Burt has and is making.

Readers of the Journal might be interested to know that in addition to increasing submissions and since becoming an online open access journal, we are attracting contributions from countries such as India, Indonesia, New Zealand, Thailand, Iran and the United Kingdom. Our increasing access to reviewers also includes the aforementioned countries but has also extended further to recently including an academic reviewer from Norway!

While we utilise many College members and Australian health management academics as reviewers, we increasingly have to look further afield for our reviewers. That utilisation extends into contributions from beyond the health management schools to public health, business and public policy schools. This means that the APJHM and ACHSM are both being exposed to a wider and increasingly international audience.

We would like to take this opportunity to thank all of those colleagues who willingly provide peer review services to the Journal. Your contribution is most appreciated.

Since we have gone electronic and it is possible to provide reports from that system, I am pleased to advise that more than 50% of articles submitted have been research articles. More than 20% are review articles and more than 12% have been about the analysis of management practice.

Thank you for your support and contributions.

DS Briggs BHA(NSW), MHM(Hons), PhD(UNE), DrPH (NU-Hon), FCHSM, CHE, FHKCHSE
Editor

IN THIS ISSUE
GENERAL SUPPLEMENT

This general supplement has been added to the first Special Issue to ensure commitment to our existing authors and to the increasing number of articles being submitted to the APJHM for publication.

The supplement commences with a review article by Malone and Anderson that seeks to provide greater understanding of the underlying principles of the multi-purpose service model, now well established in rural Australia. It identifies from the literature key issues and concludes that this model continues to provide the most practical use of resources through which to provide healthcare services to small rural communities.

O'Connor, Tan and Lau in their research article make a further contribution to our knowledge of palliative care services as they are experienced in Victoria, Australia. The article describes the palliative care satisfaction survey development and validation and the positive outcomes of being able to benchmark, compare and contrast service satisfaction.

Bolton, Rivas, Prachar and Jones provide a research note with a micro dimensional focus on the impact of visual cues of being watched on hand hygiene compliance, a major concern to those interested in improved patient safety. Le Phung Tan and Fitzgerald in a research article report on patient satisfaction as a measure used in evaluating hospital performance in the Vietnamese healthcare context. They report the findings of a survey involving 985 in-patients and describe the findings of that evaluation.

Schneider provides an analysis of management practice article that describes a comprehensive approach to strategic planning based on the literature and on the author's personal contributions and experience in this area. Our final contribution is from Davis and Beale who provide a review article emphasising that it is time for the inadequate safety and quality culture in Australian hospitals to be better addressed. They emphasise the importance of multi-disciplinary care teams and their ongoing education and also focus on the influence of bullying within what they have described as a poor safety and quality culture.

Understanding the Need for the Introduction of the Multi-Purpose Service Model in Rural Australia

L Malone and J K Anderson

Abstract

Aim: This article provides a commentary on the implementation of the Multi Purpose Service (MPS) healthcare program and the underlying principles that govern the administration of MPS within the Australian public health system.

Background: Existing funding models for acute care services do not apply to MPS, which increases the pressure on small rural areas with decreasing populations to maintain health care services.

Evaluation: A database search yielded 147 articles and 23 were identified as being relevant to the topic.

Key Issues: Key issues were identified from the evaluation of the literature and included: poor health in rural communities; the need for collaboration between governments; unique design of an MPS; and the need to consider community and staff perspectives.

Conclusions: In the absence of any other sustainable model of health care delivery being developed or implemented within Australian rural and regional areas, the MPS model of care is the most practical use of financial and human resources to provide healthcare services for these small communities.

Key words: Multipurpose services; staff and community perspectives; rural and remote health.

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Aim

To inform the understanding of the need for multi-purpose health services in rural Australia and describe the underlying principles that govern the administration of MPS within the Australian public health system.

Background

Multi-Purpose Service (MPS) health facilities have been in existence in rural Australia for over 30 years. The number of MPS health facilities continues to increase with this type of facility being seen as the gold standard for rural and regional areas. The literature is noticeably silent about the need for this type of health service model and the reason for the introduction of this type of facility in rural Australia. This article seeks to explore the reason for this model's implementation and the underlying principles that govern the administration of such services within the Australian public health system so that managers and clinicians who currently work in these facilities, or who are seeking to move to regional areas, understand the difference between this type of model and other acute care and aged care facilities currently in existence.

Evaluation

A database search of Ebscohost Health (including CINAHL, Academic Search Complete, Health Business Full Text Elite, Health Source, Psychology & Behavioural Sciences Collection and SocINDEX) was undertaken followed by a desktop search of the grey literature. The search terms: 'multi-purpose health service', 'MPS health' were used for both the

database and grey literature searches. This search yielded a total of 147 articles. Duplicates of articles identified through the database search were removed and an initial screening was undertaken of titles and abstracts. Following this seven full text articles remained and were assessed for eligibility. The inclusion criteria were that the article was related to MPS in Australia. The grey literature search strategy was similar except that websites and identified documents such as government and professional organisation reports were accessed and reviewed, resulting in an additional 16 articles for inclusion.

Key issues

The literature was evaluated and the following key issues were identified: poor health in rural communities; the need for collaboration between governments; unique design of an MPS; and the need to consider community and staff perspectives. Each of these themes will be discussed in greater detail.

Poor health in rural communities

There are significant differences in the health and wellbeing of communities living in rural areas compared to those living within major regional and metropolitan areas. Reports indicate that the health of people living in rural Australia is generally worse than that of their metropolitan counterparts. [1,2] It is acknowledged within the literature that poor rural health can be related to socio-economic disadvantage, shortage of healthcare providers, poor personal health management, greater exposure to injury risks, lack of public transport, poor road quality and geographic isolation. [2-4]

Following a review and subsequent parliamentary report (commonly known as the Sinclair report) [5] on the status of rural clinical services, the need for change was highlighted. This report called for a rationalisation of rural health services to ensure their viability for the future taking into account the difficulty in remaining economically solvent and being able to staff these facilities to deliver safe patient care. At the time of the Sinclair report, rural communities commonly had independently run aged care facilities and State run acute care services. The majority of acute care services were considered economically unviable and the threat of closing these existing facilities was imminent. The Sinclair Report provided a solution to the existing concern for maintaining health care services in these rural and regional areas. [5]

The need for collaboration between governments

Following the release of the Sinclair report the MPS Program was developed as a joint initiative between the Commonwealth and State Governments of Australia to address these rural health problems. [6,7]

When the MPS Program began to implement the model, its objectives were to:

- improve the flexibility of services;
- provide health and aged care services more cost effectively;
- improve the coordination of health and aged care services; and
- enhance the responsiveness of health and aged care services to identified community needs. [8,9]

There is little in the literature that provides any evidence that the original objectives of the MPS Program have actually been met, yet the model continues to be implemented in rural and regional Australia. Currently there are 134 MPS in operation with more under development. [10]

In Australia, economic rationalism has led to funding based on activity levels for acute care services in the belief that it is a better way to manage health services in a financial framework. [11,12] Although the MPS model contains acute care services, low levels of patient activity make these sites inappropriate for activity-based funding models leading to difficulties in rationalisation. [11] These policies have resulted in reduced choice of, and tenuous funding for, services for the rural population which frequently leads to public cynicism and distrust of politicians. [12] Despite these policies, healthcare costs continue to rise [1, 13] and access to health services for people in rural and remote communities has not improved. [14] It is critical to understand what constitutes an MPS and what makes the MPS model different from other acute or aged care services.

Unique design of an MPS

There are many variations to the possible configuration of an MPS. Each is unique to meet the needs of individual communities. The particular design and configuration of an MPS is often as a result of community consultation and health service planning initiatives combining both federal and state requirements. [15]

Funding for new developments are provided through the Multi-Purpose Service Program. [15] Multi-Purpose services are legislated as flexible care services under the *Commonwealth Aged Care Act 1997* (Section 49) which requires them to provide an integrated service consisting of:

(a) residential care; and

(b) at least one of the following:

    (i) a health service provided by a State;

    (ii) a home and community care service;

    (iii) dental or other health care;

(iv)   transport services;

(v)   community care under the Act;

(vi)   a service for which a Medicare benefit is payable under the *Health Insurance Act 1973*;

(vii)   the provision of a pharmaceutical benefit under the *National Health Act 1953*;

(viii) a service that the Minister nominates, in an agreement with the responsible Minister of the State, as an appropriate service. [16]

In Australia, healthcare services are provided by a complex combination of Commonwealth and State Government funding. This system has created a division of government responsibilities where the Commonwealth manages the welfare budget (including aged pensions, nursing home subsidies, Medicare) while the State is responsible for the public hospital system. [12] This arrangement inhibits movement of funds across program boundaries, creating service fragmentation and duplication. [1] This current arrangement of multiple funding bodies results in health care services shifting costs from one funding provider to another which does not always provide optimal health outcomes. [1,17] The MPS model is designed to allow pooling of funds across program boundaries in order to streamline healthcare services in small rural communities.

The need to consider community and staff perspectives

The MPS Program was introduced prior to this time of sweeping economic reforms and aimed to more appropriately meet the needs of local communities. [5, 18,19] When faced with this history of decreasing public expenditure it was not surprising that some small rural communities interpreted the new model of health service delivery as a reduction in health services. [20, 21]

The dynamic of small rural communities differs from their metropolitan counterparts. The viability of these communities often hinges on their health services as major employers. Possible loss of employment within health services may have a destabilising effect on entire communities. At the initial introduction of the MPS Program, resistance was experienced from some local communities as they perceived that the implementation of an MPS was creating a reduction in health services therefore resulting in a loss of jobs. Although some jobs losses occurred the amalgamation of acute and aged care services, through economies of scale increased the viability of these services for the future. [5, 20, 22]

Consultation with communities was poorly implemented with statisticians providing explanations as to the need for change. Much of the consultation was persuasive rather than being consultative. This only added to the resistance experienced with communities. When faced with either the closure of their local health service or to accept an amalgamated service many communities felt forced into accepting this model of care. [18-21, 23]

Similarly staff also raised concerns about the MPS model of health service delivery. Many did not understand the financial advantages of what the model provides and its ability to adapt to individual community needs. Common misconceptions from staff included a loss of skill, expertise and employment. They feared a loss of acute care beds even though many were underutilised, with the perception of becoming 'just a nursing home'. Conversely staff from aged care facilities raised concerns about dealing with acute and emergency care, due to a lack of experience or skill in providing those services. [20]

Conclusion

It is well recognised that there are health inequities between rural and metropolitan areas in Australia. The literature supports this with a strong discussion of poor health in rural communities. In the absence of any other sustainable model of health care delivery being developed or implemented within Australian rural and regional areas, the MPS model of care remains the most practical use of financial and human resources to provide health care services for these small communities. Collaboration between government bodies can assist in providing these small rural communities with the support they need to maintain health services. The challenge for health planners and administrators is to develop a model in consultation with local staff and communities which meets their unique needs. It is hoped that communities now faced with the prospect of obtaining an MPS within their towns can learn from the experience of their rural neighbours and improve the model and adapt it to what suits them best.

Competing interests

The authors declare that they have no competing interests.

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Developing an Instrument for a State-Wide Palliative Care Satisfaction Survey in Australia

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Abstract

In the State of Victoria, Australia, there was an identified need for a validated instrument to measure the satisfaction of people receiving palliative care. The process of gaining sector-wide cooperation to collect satisfaction data across many settings and models of care had been a challenge for many years. This was finally achieved in 2007, particularly when driven by the requirement that funding was contingent on meeting the Victorian Government's key performance indicators in relation to satisfaction. What has emerged is the ability to report to government and the sector, to compare and contrast service satisfaction and these data being used to enable improved care provision.

This paper outlines the process of developing and validating the Palliative Care Satisfaction Instrument (VPCSI). Continued annual use of the instrument enables ongoing collection of benchmark data for sub-groups, confirmation of core components and other psychometric consolidation measures.

Abbreviations: CCFSS – Critical Care Family Satisfaction Survey; DHS – Department of Human Services; FAMCARE – Edmonton Zone Palliative Care Program; KMO – Kaiser-Meyer-Olkin; POS – Palliative Care Outcome Scale; VPCSI – Victorian Palliative Care Satisfaction Instrument; VPSM – Victorian Patient Satisfaction Monitor.

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Introduction

The Cancer and Palliative Care Unit of the Department of Human Services in Victoria, Australia (DHS) identified the need for a validated instrument to measure the satisfaction of people receiving palliative care and their carers in 2007. [1] Gaining sector-wide cooperation in soliciting objective and comparable satisfaction data had been a challenge for many years. Establishing a requirement that funding was contingent on meeting the Victorian Government's key performance indicators was a significant driver for services' involvement. The consequent ability to report to DHS as well as the sector, to enable improved care provision, was the main factor driving the development of an instrument.

The World Health Organisation (WHO) defines palliative care as 'an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual'. [2]

Satisfaction with care of this type relates to a number of subjective and qualitative factors in complex ways that make objective assessment very difficult. [3] Methodological issues such as the potential impact of either direct or indirect questions on responses, severe illness and frailty of patients and possible distress of family carers also further complicate satisfaction assessment processes. [4]

Two examples of meta-analysis were identified [3, 4]. Both meta-analyses revealed that satisfaction was either not defined at all, or a range of definitions used, while also making the assumption that satisfaction equated with good quality care. Aspinal et al [4] identified that there is little consensus about which factors are true indicators of

satisfaction although factors that occurred more frequently included provision of information, pain control and the presence of staff competencies such as humaneness, confidentiality, availability and ability to reduce anxiety. Wen and Gustafson [3] particularly stressed the lack of common domains, the differing content of domains with the same titles and considerable variation in the methodologies utilised in assessment tools.

This paper outlines the process of developing the Palliative Care Satisfaction Instrument (VPCSI).

Instrument development

Literature review

The first step of the instrument development process was to create a comprehensive list of items that represent the various components of the Victorian Government's key performance indicators in relation to satisfaction. An extensive literature review was conducted with the specific aim of identifying existing recent survey instruments that might meet the needs of DHS. The terms used were palliative care, instrument, questionnaire, satisfaction, health professional, patient, carer, and client in various combinations. Electronic searches were carried out on databases: PsychINFO, Medline, Pubmed and Web of Science.

The literature review identified four instruments that had been used to assess the satisfaction of people receiving palliative care and their carers. There were Edmonton Zone Palliative Care Program (FAMCARE), [5] Palliative Care Outcome Scale (POS), [6] Critical Care Family Satisfaction Survey (CCFSS), [7] and Victorian Patient Satisfaction Monitor (VPSM). [8]

Prominent amongst these was FAMCARE [5] showed strong factor loadings on both information and general care. [6] This instrument has been utilised elsewhere in Australia [7] including since the time of this original literature review. [8] POS [6] is available in two versions, one for patients able to respond and an adapted staff-rated version for patients unable to complete the survey. This instrument includes assessment of symptoms as well as some items related to satisfaction. This instrument has also been adapted for used in Australia. [9] CCFES was developed to assess satisfaction of family members as a proxy for patient satisfaction critical care and also been used in Australia. [10] An earlier VPSM [8] instrument had been developed to assess patient satisfaction with care in public hospitals. While this instrument had been found satisfactory, it was also recognised that palliative care involved components and outcomes that differed from those in general medicine.

[11] Since the original literature review, two further studies have been published on nationwide surveys in Japan and Korea, which attempted to assess satisfaction or to identify the determinants of satisfaction. [12,13]

Although three existing instruments identified during the literature search (FAMCARE, POS and VPSM) as having some appropriate items, they were not considered appropriate in meeting the Victorian Government's key performance indicators in relation to satisfaction.

Interview

The second step was the collection of qualitative data through interviewing 15 key leaders in the palliative care sector between January and March 2008. Thematic analysis of the interview data showed issues considered important by clients and carers largely overlapped although there were some differences in emphasis. These common issues included referral, access, expectations of the service, scope of service, integration of care, physical and psychological symptom management and choice of where the service is delivered. Carers had a few unique issues which included access to information, meeting their own needs, family involvement in care, dealing with emergencies, training for care and addressing financial and bereavement matters. Interviewees also expressed the importance of issues relating to the services providing palliative care, such as: role of interdisciplinary teams in provision of care; referral and access to services of all those who would benefit from it; the availability of resources including inpatient beds, consultation services, staff education consistency of models of care.

Expectations regarding the proposed satisfaction survey were also expressed. These included concern about the focus and language of the questions; the time and energy of both staff and clients (patients and carers) to undertake such a survey; and the importance of a longitudinal survey which would enable an understanding of change over time as well as facilitating links to benchmarking and accreditation processes.

During March and April 2008, data from the literature review and interview relevant to the both clients and carers were compiled into a single list of 'core' items. Those specific to carers or individuals receiving care in health services were compiled to either carer or health service module. The newly designed instrument comprised of four different care settings survey types (clients in the community, clients in health services, carers in the community, and carers in health services) were subsequently pilot tested.

Data analysis

The data were analysed using SPSS version 14 (Chicago, IL). The primary and secondary core items data were analysed using factor analysis to extract component factors with varimax rotation. Data from questions comprising the carer and health service modules were analysed using Pearson Correlation Coefficient.

Pilot testing

A pilot study was undertaken from mid-May 2008 to July 2008 in three palliative care service providers, two large metropolitan and one small regional service. A covering letter signed by the manager of Palliative Care Services (DHS) was distributed to 443 (49%) patients and 448 (51%) carers associated with these services. Approval was given for this distribution as a part of the quality control program. A generic reminder letter was sent to recipients one week after the original distribution.

Results

A total of 117 clients and 140 carers returned the completed survey, giving a response rate of 27% and 31% respectively; and presenting the overall response rate of 29%. It is generally recommended that a sample size of at least 300 cases are needed for factor analysis. [14] This criterion was used to exclude 80 core items. Items where fewer than half of all respondents had provided a valid answer and where Kaiser-Meyer-Olkin (KMO) Measure of Sampling Adequacy used to examine suitability for factor analysis was not suitable, the items were removed, hence 22 items were removed. Pearson's correlation coefficients were carried out for the 58 items and a further three items with the weakest relationships to overall satisfaction with palliative care were removed, leaving 55 items. The KMO was 0.499, rendering it unsuitable for factor analysis. Items were further removed and the final 35 items with KMO of 0.891 indicating it was suitable for factor analysis. The 35 items were entered into a principal component analysis with varimax rotation and an initial seven-factor solution extracted. This seven-factor solution accounted for 85.3% of the variance. Reliability of the factors were excellent, Cronbach's alpha = 0.846. However, with a sample size of 113, it lacks statistical robustness and items loading on factors that have the poorest overall factor and lowest reliability were removed and principal component analysis were further carried out. The final 21 items, four-factor solution was extracted and accounted for 83.87% of the variance (see Table 1). Each factor had at least two items with factor loadings above 0.8, suggesting the four-factor solution to be statistically more robust than the seven-factor.

For the module items (carer and health service modules) descriptive analyses and Pearson Correlation Coefficient were carried out. Of the 40 items in the carer module, 30 showed significant correlations with overall satisfaction and were included (see Table 2). Of the 19 items in the health care module, 10 showed significant correlations with overall satisfaction and was included (see table 3). The question 'How satisfied have you been with the communication skills of doctors' which was excluded from the factor analyses of core items was deemed important in the specific context of health services and therefore included in the health services module.

VPCSI

The VPCSI comprises six main sections: central core questions; secondary core questions; demographic information; supporting information; carer module and health service module. [1]

The central core section comprises 21 items falling into four factors or dimensions which are: referral: staff (six items); referral: explanation (five items); care: staff (six items); and symptom management (four items). All items assess overall satisfaction with the palliative care service and are scored on five-point scale. For satisfaction scales (1 = very dissatisfied, 5 = very satisfied) and agreement scales (1 = strongly disagree, and 5 = strongly agree).

The secondary core section comprises 14 items considered to likely be part of the core section but at this time there is insufficient evidence to include them there. These items are also measured on a five-point scale. They are arranged into three factors or dimensions as follows: access and involvement with the palliative care service (five items); social: emotional and psychological support (four items); and information provided to the client (five items).

Demographic data was considered to provide important contextual information and included questions relating to age, gender, diagnosis, existence of/relationship to a carer, normal living arrangements and location in relationship to service provision. Most questions provided a series of possible answers from which the respondent was asked to choose the most relevant to them.

Thirteen items were identified as providing supporting information with potential clinical relevance. They included items about satisfaction with service provision in relation to religious/spiritual and cultural needs; respect for the individual; and satisfaction with access to aspects of palliative care service as needed including afterhours services availability; and offered a five point scale response.

Table 1: Item loading of the four-factor solution

ITEM	1	2	3	4
Referral staff respected my feelings and opinions	0.996			
Referral staff treated me like an individual and not just a number	0.902			
Referral staff showed sensitivity about my readiness to accept palliative care		0.901		
Referral staff had my best interest at heart	0.867			
Referral staff could see things from my point of view	0.836			
Referral staff were helpful in answering questions	0.822			
Satisfaction with communication skills of nurses		0.934		
Satisfaction with cooperation (teamwork) of care staff		0.896		
Satisfaction with level of expertise of care staff		0.889		
Satisfaction with communication between staff		0.882		
Satisfaction with accessibility of nurses		0.857		
Satisfaction with professionalism of nurses		0.793		
When referred, satisfaction with how clearly and simple palliative care was explained			0.982	
When referred, satisfaction with the opportunity to ask questions about the range of palliative care services			0.967	
When referred, satisfaction with the opportunity to ask questions about care options (e.g. in-hospital versus in-home care)			0.939	
When referred, satisfaction with support provided to help you come to terms with the idea of receiving palliative care			0.707	
Symptom management – fatigue				0.994
Symptom management – eating or digestive problems				0.923
Symptom management– pain				0.892
Satisfaction with speed of symptom treatment				0.726

Table 2: Carer module questions

ITEM	N	MEAN	SD	CORRELATION WITH OVERALL SATISFACTION
Help with arranging: Transport to and/or from treatments	66	3.88	1.45	0.62**
Help with arranging: Special dietary requirement for the client	56	3.96	1,29	055**
Help with arranging: Treatment for the client not covered by Medicare	23	3.52	1.56	0.55**
Help with arranging: Medications for the client not on the PBS	35	3.89	1.41	0.52**
Help with arranging: Funeral arrangement	37	3.46	1.63	0.50**
Initial support: The sensitivity of staff about your readiness to start caring for the client	109	4.14	1.27	0.40**
General support: The level of access to psychological support services, such as a counsellor or psychologist, for you personally	78	3.76	1.33	0.40**

Table 2: Carer module questions *continued*

ITEM	N	MEAN	SD	CORRELATION WITH OVERALL SATISFACTION
General support: The level of training provided to enable you to carry out specific care functions, such as managing, moving or bathing the client	68	3.56	1.63	0.39**
General support: The level of support you receive from the community	104	4.10	1.10	0.38**
Help with arranging: Medical power of attorney	42	3.62	1.65	0.37**
General support: The information provided to minimise your own physical burden	92	3.67	1.46	0.36**
General support: The efficiency of receiving urgent medical assistance from health professionals in general	119	4.27	1.04	0.36**
General support: The support provided to help you, as a carer, come to term with the idea of the client receiving palliative care	116	3.97	1.34	0.35**
General support: The information provided to minimise your own psychological burden	100	3.62	1.44	0.34**
Help with arranging: Necessary equipment	94	4,38	1.07	0.33*
Help with arranging: Home alterations	60	3.90	1.27	0.33*
General support: The level of professional help you receive as a carer	120	4.26	1.15	0.33**
Initial support: The level of support in determining HOW BEST to place the client in a palliative care or aged care facility	67	3.96	1.27	0.32**
General support: The level of support you receive from medical professionals	123	4.22	1.12	0.30**
Initial support: The level of support in deciding to place the client into a palliative care or aged care facility	72	4.06	1.29	0.30**
Coping with: The financial burden of caring	107	3.93	1.19	0.30**
Initial support: The level of information you received about what would be involved in supporting a person living with a terminal illness	120	3.76	1.38	0.30**
General support: The level of respect you have been shown as a carer	126	4.45	1.04	0.30**
General support: The overall responsiveness of health professionals	120	4.31	0,98	0.29**
General support: The ease of receiving urgent medical assistance from health professionals in general	121	4.25	1.08	0.29**
General support: The availability of medical professionals to answer questions	118	4.06	1.20	0.25**
General support: The level of concern for your own psychological wellbeing	103	3.95	1.28	0.23**
General support: The availability of medical professionals to provide information	118	4.08	1.19	0.22**
General support: The opportunities to talk to someone about your own situation as a carer	103	3.89	1.29	0.22**
Initial support: The level of professional support you received in making the decision to become a carer	105	3.72	1.44	0.21

**p < .01; *p < .05

Table 3: Health service module questions

ITEM	N	MEAN	SD	CORRELATION WITH OVERALL SATISFACTION
The explanation of routine (like meal times, visiting hours, etc)	34	4.41	1.02	0.62**
The activities provided to help you (the client) pass the time	25	3.84	1.43	0.47**
The attractiveness of the facility	36	4.44	1.05	0.43**
The quality of the food overall	33	3.79	1.09	0.42**
The general atmosphere of the facility	35	4.26		
The privacy of the room where you spend (the client spends) the most time	35	4.29	1.13	0.37*
The general level of comfort in the room where you spend (the client spends) the most time	35	4.29	1.05	0.36*
The amount of peace and quiet	34	3.91	1.9	0.34

***p < .01; *p < .05

The carer module includes items relating to specific interest of carers. Four key areas were identified which were: initial support; general support in day to day care; help with arranging services; and coping with the carer role. Thirty aspects of specific carer interest were included in this module.

Nine items were recommended for inclusion in the health service module. These investigated satisfaction with general aspects of the health service such as the physical environment; overall service delivery; and the general level of care provided.

Scoring and interpretation

The VPCSI used a means-based index (factor) scoring system. The scoring system works as follows:

1. The scores of each item within a factor are summed,
2. A total score factor is derived,
3. Scores are pro-rated to a common denominator (for example, 100) to allow for inter-factor comparison.

Discussion

The VPCSI was developed with the intention that a mean-based index factor scoring system be used, this being a simple robust approach that can easily account for missing data, while also allowing more sophisticated analyses of data if required. The instrument has been designed with a hard copy data collection process in mind this being consistent with current needs of the target population. However it is also well suited to phone interview and on-line methods. There is also the scope for intervention and quality

improvement as well as awareness of possible differing needs of clients and carers at different stages of the illness trajectory. It would also enable services to track trends in performance within their service and thereby address issues more quickly.

Continued use of the instrument enables the collection of benchmark data for sub-groups, confirmation of core components and other psychometric consolidation measures. In addition the administration of the instrument can be proactive although care would be required to avoid biased information arising from respondents filling in questionnaires at times of either high satisfaction or strong dissatisfaction. Further detail about the application of the VPCSI has been published elsewhere. [15]

Conclusion

The development of the VPCSI is an important landmark for the measurement of satisfaction with palliative care in Victoria and potentially elsewhere. It is the result of a wide ranging and thorough consultation process and appropriate statistical and psychometric analyses.

Acknowledgements

Competing interests

The author declares that she has no competing interests.

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The Observer Effect: can being watched enhance compliance with hand hygiene behaviour? A randomised trial

P G M Bolton, K Rivas, V Prachar and M P Jones

Abstract

Bateson and Shelby provide evidence that cues of being watched can be a powerful mechanism inducing those observed to change behaviour. We designed and conducted a randomised controlled trial to assess the impact of visual cues of being watched on hand hygiene compliance. This did not demonstrate improved hand hygiene compliance associated with cues of being watched: compliance for wards with a 'cleanse your hands' poster was 87.3% and for wards without the poster it was 84.9%. This difference failed to reach statistical significance (OR=1.73, 95% CI 0.71- to 4.24, p=0.23).

Abbreviations: POWH – Prince of Wales Hospital.

Key words: cues of being watched; behaviour change methods; hand hygiene compliance.

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Introduction

Being watched can affect hand-washing practice. [1,2,3] Bateson and colleagues provide evidence that cues of being watched can be a powerful mechanism inducing those observed to change behaviour; in their case, they show how being observed increases contribution to a public good. [4] In their experiment the presence of images of pairs of eyes was associated with increased contributions to a coffee room honesty box. They postulated that the perception of being watched leads to more socially approved behaviour. More broadly, there are multiple studies across differing domains of activity suggesting that behaviour alters towards more honesty and compliance when people know they are being observed. For example, the mere presence of an observer in a public restroom increased hand-washing rates by 39% to 77%. [5]

It is not clear whether this phenomenon holds amongst healthcare professionals. Does the systematic application of an observer model lead to sustained behaviour change in complying with specific quality and safety policies such as hand hygiene requirements? If it does it may offer an efficient mechanism to improve hand hygiene compliance.

Hand hygiene has been identified internationally to be a high priority for the prevention of healthcare associated infection. [6] Procedures for hand hygiene have been developed and data measuring the compliance of each hospital in Australia and elsewhere are collected at a national level. [7] This approach audits compliance with each of five 'hand hygiene moments' (before touching a patient; before clean/aseptic procedures; after body fluid exposure/risk; after touching a patient; and after touching patient's surroundings) at each encounter between a patient and healthcare worker. An

Figure 1: The 'cleanse your hands' poster

overall score can then be created for an individual healthcare worker, ward, class of healthcare worker (i.e. doctor, nurse or allied health worker), or hospital by summing the compliant moments over the possible moments.

Hand hygiene is a socially appropriate public good. One would therefore expect that the perception of being watched would increase contributions to it. We sought to explore whether the approach taken by Bateson and Munger would improve compliance with hand hygiene in a large teaching hospital already performing at high levels.

Setting

Prince of Wales Hospital (POWH) is a 570-bed public adult teaching hospital in inner-metropolitan Sydney, New South Wales. POWH has applied various techniques to increase hand hygiene compliance among healthcare workers and has been auditing compliance with hand hygiene using the nationally approved approach three times annually since October 2009.

The audit has been gradually extended on each occasion that it has been conducted so as to cover an increasing proportion of the hospital's wards. Differential compliance has been observed between nurses, doctors and allied health workers on each occasion the audit has been undertaken. Prior to this study compliance with hand hygiene was audited in POWH at 68% for doctors and 81% for both nurses and allied health workers. Australian national data suggests rates of 62% for doctors, 74% for allied health workers and 80% for nurses. [9]

Method

We designed and conducted a randomised controlled trial to assess the impact of visual cues of being watched on hand hygiene compliance. Nineteen wards participated in a hand hygiene audit in October 2012, of which twelve were randomly allocated to receive the intervention. The intervention consisted of placing a poster (figure 1) with a picture of a pair of eyes with words 'Have you cleansed your hands?' on it near each sink and in each room that did not have a sink in the intervention wards prior to the audit. The project was assessed by the South Eastern Sydney Local Health District (Northern Sector) Human Research and Ethics Committee to be a quality improvement activity not requiring ethical review.

Have you cleansed your hands?

Data from the routine October 2012 audit were used to test the hypothesis that the 'cleanse your hands' posters were associated with an improvement in compliance with hand hygiene practice. A logistic regression model was applied to analyse the compliance data to gain insight into the impact of the presence of the 'cleanse your hands' posters, taking into account healthcare worker type (nurse, doctor, allied health worker) as indicator variables, fitting an interaction between the presence of the eyes poster and the healthcare worker type and controlling for clustering at the ward level. Standard errors in the model were adjusted for the intra-class correlation that allows for non-independence among staff within a ward as implemented in the Stata statistical software. [8] The interaction between intervention and healthcare worker type was assessed to determine whether the effect of the intervention depended upon the healthcare worker type.

Results

Overall hand hygiene compliance was 86.5% (3,674 moments out of a possible total of 4,246). Compliance for

wards with the 'cleanse your hands' posters was 87.3% (2,472 out of 2,833 possible moments) and for wards without the poster it was 84.9% (1,200 out of 1,413 possible moments). This difference failed to reach statistical significance (OR=1.73, 95% CI 0.71- to 4.24, p=0.23).

Discussion

Our findings do not provide convincing support of the hypothesis of Bateson that the perception of being watched leads to more socially approved behaviour, in this case compliance with hand hygiene guidelines. We suggest three reasons why this may be so. First, hand hygiene compliance was already high, and so the possible proportionate increase was necessarily lower. Second, major efforts had been made prior to our intervention to improve hand hygiene rates. Consistent with diminishing marginal utility, these earlier efforts may have 'used up' much of the capacity to change, so that a greater effect might be seen on a naïve intervention group.

Third, we cannot rule out that Bateson's hypothesis may be not well-founded or is inapplicable, i.e. the presence of eyes may not lead to more socially approved behaviour under these kinds of conditions, or improved hand hygiene may not be perceived by participants as more socially appropriate. Bateson's research used five different pictures of eyes, each with a different expression. Our eyes, it may be argued, look aggressive. This is the case for only one or two of Bateson's pictures of eyes. It may be that this variety of expression is the reason that Bateson was able to demonstrate an effect where we did not.

A potential imitation of our study was that the control was a no poster condition, rather than a poster without eyes that said 'cleanse your hands'. Another was that more posters in prominent places might have increased the number of staff in the intervention wards noticing them.

Where it is effective, cues of being watched seems a relatively efficient way to encourage socially acceptable behaviour, particularly in comparison to some other initiatives intended to change behaviour. For this reason it is important to elucidate those situations in which it can be successfully applied.

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Competing interests

The authors declare that they have no competing interests.

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A Study on Patient Satisfaction at Khanh Hoa Provincial General Hospital

Phung Tan Le and G Fitzgerald

Abstract

Patient satisfaction has been considered an indispensable measure in the process of evaluating hospital performance. A patient satisfaction survey can help explore possible gaps in hospital service to improve its quality.

The study was conducted based on a random sample of 985 in-patients who were already discharged within three months. A 26-item patient satisfaction scale was used to evaluate respondents' satisfaction with the hospital service. Univariate and multiple analyses were used to examine the relationship between satisfaction and patients' socio demographic characteristics. T test, ANOVA, and regression model were used for analysis.

The results showed a proportion of 68 per cent satisfaction with the hospital's service. The most dissatisfied dimension was Responsiveness that relates to waiting time for doctors' and nurses' responses and administrative procedures. There were no significant differences in satisfaction regarding patients' gender, religion and health insurance status. Older people were likely to be more satisfied than younger ones. Patients who were living in remote areas were likely to be more satisfied with the hospital service.

Further studies should be conducted to confirm the five-factor structure of the scale. More attention should be paid to the dimensions of Assurance, Reliability and Empathy to improve hospital service quality.

Key words: patient satisfaction; SERVQUAL; SERVPERF; Khanh Hoa province, Vietnam.

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Background

There have been many studies examining the relationship between service quality and customer satisfaction. Although debates relating to the causal relationship between these two concepts are yet to be resolved, [1, 2] researchers agree with the evidence that there is a significant association between customer satisfaction and the quality of service. [3-5] As a result, customer satisfaction is considered a reflection of service quality. The healthcare sector is not an exception. In other words, patient satisfaction conveys the quality of healthcare. Therefore, patient satisfaction has been considered an indispensable measure in the process of monitoring and managing hospitals. [6]

A study by Aharony [7] demonstrated that satisfied patients were more likely to continue using medical services, to participate in their own treatment and to cooperate with their healthcare providers by disclosing important clinical information and by adhering to treatment regimens. This results in a better health outcome for patients. Further, patient satisfaction surveys may help healthcare providers identify potential areas for improvement in service quality. Patient satisfaction surveys also provide hospital managers with feedback regarding patients' concern, needs, and perceptions of treatment. [7] These issues indicate the importance of patient satisfaction in healthcare generally and hospital service particularly.

Studies show that implementation of patient-centred care and a high level of patient satisfaction has been demonstrated to be associated with improved health

outcomes and health service efficiency. [8] A high level of patient satisfaction makes the hospital staff more content with their job (job satisfaction), enhances patients' trust and therefore results in greater compliance. [9,10] In an article entitled 'Patient satisfaction: the indispensable outcome', Bolus et al [6] argued that 'without acceptable levels of patient satisfaction, health plans may not get full accreditation and will lack the competitive edge enjoyed by fully accredited plan'. Andaleeb [11] stated that 'Hospitals that fail to understand the importance of delivering customer satisfaction may be inviting possible extinction'. These points of view again emphasise the 'indispensable' task of conducting patient satisfaction surveys in the process of evaluating hospital performance.

There are still inconsistent findings in the relationship between patient satisfaction and socio-demographic characteristics. Some studies showed a significant relationship between satisfaction and socio-demographic factors. [12,13] Males and older people are reported in many studies to be more satisfied than females and younger ones. [14-18] In contrast, Priporas et al [19] reported that males and young people tended to rate satisfaction a little higher than females and older people. However, Choi et al [20] did not find any differences across age, gender, and service type subgroups. Consistently, a cross-sectional study conducted by Yardan et al [21] at the emergency department of a tertiary university hospital in Hong Kong showed no relationship between overall patients' satisfaction with their socio-demographic characteristics. Tucker et al [22] also indicated that demographic variables such as age, gender, education, race, and marital status did not have any moderating effect on satisfaction.

This study aimed to evaluate patient satisfaction in Khanh Hoa 1,000-bed Provincial General Hospital, examine possible associations between patient satisfaction and related patients' characteristics and some implications for quality of care of the hospital.

Methodology

The study population is in-patients and/or their relatives who had taken care of the patients in the hospital. The patients were already discharged from the hospital within three months at the time this study was carried out. The rationale for this was to avoid possible response bias because of the patients' concerns about mistreatment while they were in hospital to answer the questionnaire. The reason for the period of three months after being discharged from the hospital is to optimise patients' recall of their experiences. [23]

Sample size n was calculated based on the following formula applied for a finite population, [24] where we assumed that n/N > 0.05:

$$n = \frac{N z^2 p (1 - p)}{d^2 (N - 1) + z^2 p (1 - p)}$$

Where N is the population size – the number of inpatients discharged within the past three months; p is the expected proportion of patient satisfaction in the population; d is the absolute precision; and $z_{1-\alpha/2}$ is the standard normal Z value corresponding to a cumulative probability of $1 - \alpha/2$. Its value for a two-sided test is 1.96 for 95% confident interval.

Because the expected proportion of patient satisfaction in the province is unknown, p = 0.5 for the optimal sample size was chosen. According to the 2011 report of the provincial hospital, the average number of patients discharged in three months was 12,000. With the absolute precision of five per cent, the sample size calculated was n = 373. Assuming the response rate is around 70 per cent, by adding the percentage of not responding 30 per cent to the sample size, the computed sample size was n = 480. Because the sampling method is stratified systematic sampling, the sample size needs to be adjusted by the design effect at D = 2. As a result, the final sample size was n = 480 x 2 = 960, rounding up to 1,000 patients.

Stratified systematic sampling was used to recruit patients into the sample. Patients were chosen based on the patient-recorded data saved in the computer server of the provincial hospital. A list of patients discharged within the last three months was created and sorted by resident location and then by gender and age. A sampling interval was calculated by N/n that was approximately ten. A random number r between one and ten was chosen by STATA package. The first patient to be chosen was the r th patient in the sampling list. Every tenth patient, started at the first patient chosen as previously noted, in the list was chosen for inclusion in the sample.

Before this study was conducted in 2012, a pilot survey had been implemented to examine the reliability and validity of the patient satisfaction scale. [25] The scale was developed based on the skeleton of perception part of SERVQUAL instrument, [26] using five-point Likert scale, ranging from strongly disagree (1) to strongly agree (5) with a neutral point (3). The final 26-item Patient Satisfaction Scale (PSS) includes five dimensions of patient satisfaction, namely Assurance (nine items), Empathy (four items), Tangibles (three items), Reliability (three items), and Responsiveness (seven items) as a result of exploratory factor analysis. The

scale also showed the convergent validity by the evidence of a significant regression model of the overall satisfaction variable against the five constituent factors of the scale. [25]

Expectation Maximisation algorithm was used to substitute missing data of the scale as suggested by some authors. [27-29] Analysis of variances (ANOVA), t student test, and regression analysis were used to analyse the possible associations between outcome variables and explanatory variables. The Bonferroni approach was used to uncover the real difference among pairs of variables in cases of using ANOVA technique. Multivariate analysis was used to examine the associations between the satisfaction and other independent variables together and to discover the possible models explaining these associations.

The SPSS version 19.0, and STATA version 12.0 were used to analyse data.

The Ethic Approvals have been obtained from Queensland University of Technology Human Research Ethics Committee (Approval number 1100000549) and Khanh Hoa Provincial Health Service.

Results

Among 1,000 questionnaires delivered, 985 were returned to the principal researcher, accounting for 98.5 per cent response rate. However, there were four respondents less than 18 years of age and therefore excluded in analysis. As a result, the final sample was 981.

Cases with a half or more of variables composing the scale missing were excluded for analysis. Missing analysis revealed three such cases and therefore not included in the analysis. Among 26 variables of the scale, missing values range from 0.5 per cent to 2.9 per cent. This missing proportion was less than five per cent, an acceptable level for multiple analyses. [30]

The most missing variable was 'income' with 341 cases missing, accounting for 34.8 per cent. This is understandable because income is a sensitive issue in Vietnamese culture. People usually do not want to report their real income or report differently. Variable 'Age' had 53 missing values. There were missing values for the variables 'distance to the hospital', 'marital status', and 'occupations', accounting for 10.2 per cent, 5.5 per cent, and 5.7 per cent of the sample, respectively. The variable of 'overall satisfaction' had 17 missing values (1.7 per cent).

Totally, regarding 26 constituent items of PSS scale, analysis of missing patterns found three cases with more than a half of variables missing. For the variable 'overall satisfaction', there were another two cases with more than a half of this variable missing. These cases were excluded in the analysis, leaving the final sample size of 976.

Expectation Maximisation imputation was used to substitute missing data as suggested by some authors. [27-29] This substitution was only made for the 26 items of the scale and the variable 'overall satisfaction'. The factor scores were obtained by the means of the individual items that constitute that factor. The reason for taking means but not the sum of scores was that not all dimensions have the same number of items. However, the scale score were calculated by the sum of item scores to get more accurate examination. Therefore, the scale score will range from 26 to 130 with the mean 78.0.

Baseline characteristics

Of 976 patients, the majority (nearly 68 per cent) came from Nha Trang City where the hospital is located. Females consisted of 63.4 per cent the sample.

Among 923 respondents who reported their ages, more than half were 40 years old or younger (54.7 per cent) with mean ages of 42.5, ranging from 18 to 90. Most of patients were from the Kinh group accounting for 98.6 per cent of the sample (this proportion in the whole province is 93.3 per cent). Eight one per cent of respondents were married and a small number widowed (7.6 per cent). Nearly 70 per cent respondents reported as having no religion. The distribution of patients' occupation was diverse, ranging from farmers to governmental officers. Three fourths of patients were covered by health insurance. Only 54 per cent of respondents reported themselves as in-patients; others were patients' relatives who looked after the patients during the time they were hospitalised for treatment. Regarding respondents' monthly incomes, as previously mentioned this sensitive variable had a large range, from 70,000 VND to 30,000,000 VND (equivalent to 3.5 and 1,500 AUD, respectively at that time). This range may demonstrate unreliable data and may not reflect the real income of respondents. Where 23.3 per cent patients were living more than 20 kilometres far from the hospital, nearly half were living five kilometres or less from the hospital (45.6 per cent).

Descriptive statistics of the scale

Descriptive statistics of the scale and related factors (dimensions) are illustrated in Table 2. The preliminary analysis of the scale scores showed that the scale mean score is 82.6 (SD = 11.99), slightly higher than the average score at 78.0.

The highest mean score (3.5) was at the dimension of Assurance. Assurance in the scale implies concerns, attention and professional capacity of doctors and nurses.

Table 1: Baseline characteristics of the main patient survey

VARIABLE (N)	N	PER CENT
Location (N=976)		
Nha Trang City	667	68.3
Cam Ranh City	16	1.6
Ninh Hoa District	90	9.2
Van Ninh District	48	4.9
Dien Khanh District	78	8.0
Cam Lam District	54	5.5
Khanh Vinh District	20	2.0
Khanh Son District	3	0.3
Gender (N=975, missing 1)		
Male	357	36.6
Female	618	63.4
Age group[a] (N=923, missing 53)	42.5±16.9	
Range: 18-90		
18-30	272	29.5
31-40	234	25.3
41-50	152	16.5
51-60	113	12.2
> 60	152	16.5
Ethnicity (N=973, missing 3)		
Kinh	959	98.6
Raglai	10	1.0
Other	4	0.4
Marital status (N=922, missing 54)		
Single	95	10.3
Married	747	81.0
Divorced	10	1.1
Widowed	70	7.6
Religion (N=976)		
Yes	294	30.1
No	682	69.9
Occupation (N=920, missing 56)		
Unemployed	48	5.2
Farmer	115	12.5
Fisher	31	3.4
Worker	159	17.3
Teacher	28	3.0
Government officer	95	10.3
Business	123	13.4
Retired	58	6.3
Housework	187	20.3
Health Insurance (N=976)		
Yes	723	74.1
No	253	25.9
Patient (N=952, missing 24)		
Yes	723	74.1
No (patient's relative)	253	25.9

Table 1: Baseline characteristics of the main patient survey *continued*

VARIABLE (N)	N	PER CENT
Income[a,b] (N=636, missing 340)		
Range: 70 – 30,000	2,504±1,715	
Distance from Hospital		
≤ 5 km	400	45.0
>5 – 10 km	185	21.1
>10 – 20 km	88	10.0
>20 km	20.4	23.3

Notes: [a] mean±SD; SD: Standard deviation; [b] incomes in 1,000 VND

Table 2: Descriptive statistics of the PSS scale and related factors

FACTORS (N = 976)	MEAN	SD	SE
Assurance	3.48	.588	.019
Responsiveness	2.69	.560	.018
Tangibles	3.25	.646	.021
Reliability	3.39	.665	.021
Empathy	3.13	.666	.021
Scale scores	**82.62**	**11.988**	**.384**

Note: SD: Standard deviation; SE: Standard Error

Table 3: Univariate analysis of patient satisfaction scores and socio demographic characteristics

DIMENSIONS	ASSURANCE	RESPONSIVENESS	TANGIBLES	RELIABILITY	EMPATHY	SCALE SCORE
Gender (n = 976)						
Male	3.48	2.72	3.29	3.38	3.11	82.81
Female	3.48	2.68	3.24	3.39	3.14	82.57
p values	.875	.221	.235	.813	.423	.759
Age group (n = 923)						
18 – 30	3.45	2.69	3.21	3.32	3.07	81.81
31 – 40	3.47	2.65	3.18	3.38	3.08	81.87
41 – 50	3.45	2.65	3.24	3.43	3.13	82.14
51 – 60	3.58	2.84	3.39	3.47	3.25	85.73
>60	3.56	2.76	3.39	3.48	3.26	84.97
p values	.151	.016	.002	.086	.011	.003

Table 3: Univariate analysis of patient satisfaction scores and socio demographic characteristics *continued*

DIMENSIONS	ASSURANCE	RESPONSIVENESS	TANGIBLES	RELIABILITY	EMPATHY	SCALE SCORE
Marital status (n = 842)						
Single	3.47	2.64	3.34	3.33	3.09	82.09
Married	3.47	2.71	3.23	3.39	3.12	82.61
p values	.936	.232	.068	.381	.679	.686
Religion						
No	3.48	2.70	3.28	3.41	3.14	82.89
Yes	3.48	2.67	3.18	3.33	3.11	81.98
p values	.881	.464	.025	.102	.518	.278
Health insurance (n = 976)						
No	3.47	2.71	3.30	3.39	3.12	82.73
Yes	3.48	2.69	3.24	3.38	3.13	82.58
p values	.691	.657	.177	.844	.804	.868
Distance from the hospital (n = 877)						
≤ 5km	3.38	2.73	3.14	3.32	3.08	81.17
5 – 10 km	3.40	2.60	3.15	3.27	3.03	80.18
>10-20 km	3.60	2.71	3.30	3.50	3.24	84.67
>20 km	3.75	2.82	3.55	3.61	3.35	88.40
p values	.000	.002	.000	.000	.000	.000
Location (n = 976)						
Nha Trang	3.38	2.67	3.15	3.29	3.05	80.63
Others	3.69	2.75	3.49	3.60	3.30	86.92
p values	.000	.050	.000	.000	.000	.000

The dimension of Responsiveness received the lowest mean score at 2.7. This dimension relates to responding aspects of doctors and nurses toward patients' needs as well as waiting time associated with administrative procedures.
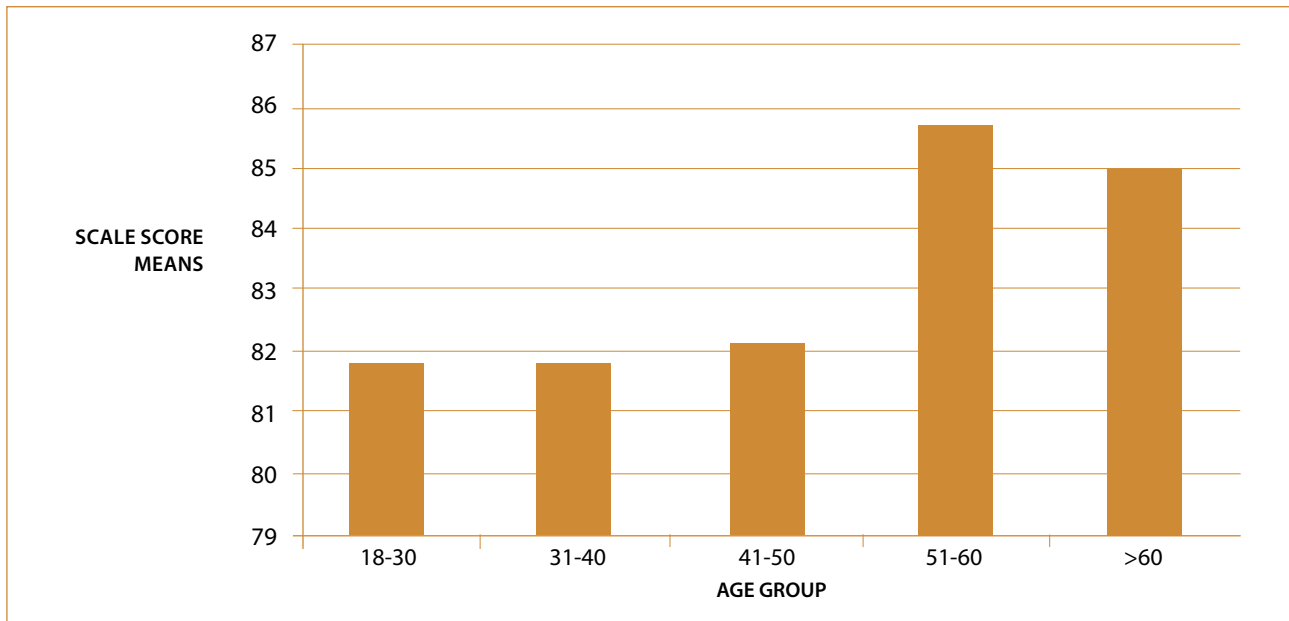
Univariate analysis

The univariate analysis revealed many significant statistics as showed in Table 3.

The result showed that there was no significant difference in mean scores of satisfaction and its constituent dimensions between males and females and the health insurance status of respondents. There was also no difference in satisfaction between single and married patients. The scale scores of satisfaction between believers and non-believers were not significantly different, although the dimension of tangibles received a significant higher mean score in non-believers than believers (p < 0.05).

Significant differences in age, respondents' resident locations and distance from the hospital have been revealed in this study. Analysis by age groups showed a trend of increasing satisfaction level proportional to age groups. The older patients are, the more satisfied they appear to be (Figure 1). Bonferroni post hoc analysis showed that the significant difference of scale mean scores was between the age group of 51-60 years and two other groups: 18-30 and 31-40 years. Other differences relating to constituent dimensions also mainly lay on the group age of 51 – 60 years.

The distance from patients' homes to the hospital was found to significantly affect their satisfaction with the hospital service. The result showed that satisfaction with hospital services was higher in patients who were living far away from the hospital. Similarly, analysis based on administrative resident location of patients showed the same result. Nha Trang City, where the hospital is located, was compared with

Figure 1: Mean Scale scores by age groups

other districts regarding patient satisfaction scores. Table 3 shows that patients who were living outside Nha Trang City were more satisfied with the hospital service (p < 0.001).

Multivariate analysis

Multivariate analysis was conducted by two different approaches: (1) Regression analysis of overall satisfaction as outcome variable against five dimensions of patient satisfaction as predictor variables. This approach aims to gauge the impact of individual dimensions on overall satisfaction: (2) Regression analysis of scale scores as outcome variable against socio-demographic characteristics of respondents as predictors. Based on the results of this regression analysis, recommendations will be made for a better quality of hospital service.

Correlation analysis of the variable overall satisfaction with five dimensions of the patient satisfaction scale showed significant correlations at the level of 0.01 (Table 4). Further,

multicollinearity diagnosis revealed all variance inflation factors (VIFs) less than five, justifying the appropriateness of regression analysis.

Regression modelling of overall satisfaction against five dimensions of satisfaction showed a significant model that explains for 49.8 per cent of overall satisfaction variance (Table 5).

A purposeful selection of covariates approach was applied for a multiple regression model with the scale scores as dependent variable and other categorical variables of socio-demographic characteristics as independent variables.

The first selection based on bivariate regression only showed three variables: age group, marital status, and distance from hospital to be eligible (p < 0.2) for the next step (p values at 0.0029, 0.009, and 0.000, respectively). These variables were then included for the initial multivariate model.

Table 4: Correlation analysis of five dimensions with the variable of satisfaction

	(1)	(2)	(3)	(4)	(5)	(6)
(1) Satisfied	1					
(2) Assurance	.692	1				
(3) Responsiveness	.211	.187	1			
(4) Tangibles	.461	.598	.201	1		
(5) Reliability	.583	.734	.184	.501	1	
(6) Empathy	.570	.719	.330	.573	.660	1

Note: All correlations are significant at the 0.01 level (2-tailed)

Table 5: Regression model of overall satisfaction on five dimensions of satisfaction

N = 976	B	B_s	P	R^2	ADJ-R^2	F TEST, P VALUE
Assurance	.684	.506	.000	.500	.498	F = 194.49 p = .000
Responsiveness	.083	.058	.016			
Tangibles	.044	.035	.228			
Reliability	.155	.129	.000			
Empathy	.097	.082	.025			
Constant	-.305		.021			

Note: β: regression coefficient, $β_s$: standardised coefficient, Adj-R^2: adjusted R^2

The initial multivariate regression model with three variables resulted in retaining three exploratory variables. The final test for one at a time inputting variables that were excluded in the bivariate regression step showed no further significant results. Consequently, the final regression model revealed three significant predictors: age group, marital status and distance from the hospital. In this model, the age group of 18-30 years, the distance of five kilometres or less, and marital status of single were considered reference groups.

The result of multivariate analysis (Table 6) showed that this significant model explains 7.7 per cent of the scale score variance. Among three significant exploratory variables, there was an increasing tendency of the scale score proportional to the distance from the hospital. A higher scale score was demonstrated significantly in patients at the ages between 51 and 60 (p < 0.05) and slightly decreased after the age of 60, although there was no significant difference between this age group (> 60) with the reference one (p >

0.05). Regarding marital status, widowed patients seemed to be more satisfied with the hospital service than single ones (p < 0.05), but with no significant difference between single and married or divorced.

Further pairwise analysis on three categorical variables showed the following results. There was only significant difference between the age group of 51-60 years with the group of 18-30 years. Except the distance groups of less than five kilometres and five to ten kilometres, all pairs of the distance groups are significantly different. Only windowed and single respondents showed significant different on the scale score of satisfaction.

Discussion

The mean PSS score at 82.6, slightly above the average (78.0) implied that patients who were admitted to the provincial hospital for treatment were just satisfied with hospital services. Assuming that the scale scores less than 78.0 is

Table 6: Regression model of scale score on age, resident location, and marital status of patients

SCALE SCORES	B	SE	B_s	P	ADJ-R^2	F TEST, P
Age group					.077	F = 7.93 p = .000
31-40	.450	1.1188	.017	.687		
41-50	.483	1.2798	.015	.706		
51-60	3.152	1.4294	.086	.028		
>60	2.184	1.4138	.067	.132		
Distance						
>5-10 km	-1.448	1.0696	-.049	.176		
>10-20 km	3.207	1.4296	.080	.025		
>20 km	6.733	1.0237	.239	.000		
Marital status						
Married	1.299	1.4069	.042	.356		
Divorced	3.729	4.6222	.028	.420		
Widowed	4.435	2.2493	.093	.049		
Constant	79.137	1.3579		.000		

Note: β: regression coefficient, SE: standard error, $β_s$: standardised β, Adj-R^2: Adjusted R^2

considered dissatisfaction, the result showed that nearly one third (32 per cent) of patients were not satisfied with the hospital service.

Univariate analysis manifested no significant association between gender and patient satisfaction. This result was consistent with other studies. [20, 22] However, patients' ages showed significant correlation with their satisfaction with hospital service. This finding was also consistent with several studies. [14-18] Additionally, the tendency of increasing satisfaction proportional to age groups suggested that older patients are more satisfied with hospital than younger. This fact may be explained by a higher expectation among younger patients. More interestingly, the study showed more satisfaction in patients who were living far from the hospital. This significant difference was shown not only in the total scores but also across the scores of its constituent dimensions. High expectation among urban residents could be attributed to this finding.

The percentage of nearly 50 per cent of the variance of overall satisfaction of patients was accounted for by the five satisfaction dimensions of the scale again confirms the convergent validity of the scale. [25] The finding suggests that the PSS should be used for evaluating patient satisfaction in Vietnamese public hospitals. Furthermore, the dimensions of Assurance and Reliability, which manifested the most impact on patient overall satisfaction, imply that approaches to improve hospital quality should focus on these dimensions.

However, a significant but weak regression model of scale score against patient's characteristics ($R^2 = 8\%$) may imply that other related factors could need to be explored in further studies in association with the patient satisfaction scale.

Conclusions and recommendations

The study has revealed some major findings regarding the satisfaction of patients who were treated in the General Hospital of Khanh Hoa province. The satisfaction level of patients who were treated in Khanh Hoa Provincial Hospital was around 68 per cent. The patients were not satisfied with waiting times and administrative procedures that were represented in the Responsiveness dimension. A higher level of satisfaction was identified in older patients and in patients who are living in remote areas. The patient satisfaction scale manifested its validity in measuring patient satisfaction in a Vietnamese context.

More studies need to be implemented in other parts of Vietnam to further confirm the PSS's reliability and validity as well as explore other patient-related factors contributing to the scale.

To improve the level of patient satisfaction with the provincial hospital, more focus should be placed on the dimensions of Assurance, Reliability and Empathy in the patient satisfaction scale. This should result in more training to improve professional knowledge and skills for doctors and nurses/midwives; and improved communication between hospital staff and patients; improved behaviours in hospital staff, including nursing-aides in interpersonal interaction. This is important in achieving a high level of patient satisfaction.

Competing interests

The authors declare that they have no competing interests.

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Appendix: The 26-item scale of patient satisfaction

Assurance
- When you have a health problem, doctor shows a sincere interest in solving it
- Nurses/midwives have good professional skills
- The doctor made an accurate diagnosis
- Nurses/midwives are consistently courteous with you
- Doctors are consistently courteous with you
- The behaviour of hospital staff instils confidence in patients
- Doctors have good professional skills
- Doctor gives you individual attention
- Nurse/midwife gives you individual attention

Responsiveness
- Doctors are too busy to response to your request promptly
- The administration procedures of the hospital take too much time
- The waiting time for lab examination and/or imaging diagnostic procedures is too long
- It takes too much time for the discharging procedure
- Nurses/midwives are too busy to response to your request promptly
- The hospital is too much crowded
- The referral procedure is too much complicated

Tangibles
- There are enough beds for patients
- The Hospital has up-to-date medical equipment
- The clinical departments are clean

Reliability
- Hospital has operating hours convenient to all patients
- When you have a health problem, nurse/midwife shows a sincere interest in solving it
- Nurses/midwives are always willing to help you

Empathy
- Nursing aides are always willing to help you
- It doesn't take too much time for you to be seen by doctor
- Nursing aides are consistently courteous with you
- The hospitalization procedures are simple

Analysis of Management Practice Strategic Planning: a comprehensive approach

S Schneider

Abstract

Objective: To describe a comprehensive approach to crafting a strategic plan for a health service organisation which incorporates the pillars of: corporate governance; service master planning; facilities master planning; business planning; clinical governance; and organisational culture to provide the framework for its development and subsequent implementation.

Background: As a senior heath executive spanning 25 years, the author experienced first hand the negative consequences of a health service not developing and maintaining a comprehensive contemporary strategic plan through key stakeholder engagement. Throughout subsequent appointments the author refined his approach to strategic planning and draws on these experiences to write this article.

Discussion: Each of the pillars is briefly discussed for the purposes of providing a definition and a considered rationale for inclusion in a comprehensive strategic plan. As each pillar is discussed, a number of elements are identified which are considered essential inclusions in this planning framework. Five key additional considerations that must be made during the development or crafting and implementation of a health service

organisation's comprehensive strategic plan are also identified and discussed. These are: multi-site organisation; functional integration; resource requirements; implementation; and monitoring the strategy.

Conclusion: The crafting of a contemporary strategic plan with six inherent pillars through key stakeholder engagement is fundamental for any organisation's long-term survival. Multi-site and functional integration challenges, resource implications, implementation needs and monitoring requirements are crucial in ensuring the successful implementation of such a strategic plan.

Through the development and successful implementation of such a plan, a health service organisation will have significantly greater confidence that the risks it confronts in the future are mitigated. A health service's board and its executive would have every justification to be optimistic of their ability to future proof the organisation when adopting the strategic planning approach discussed in this article.

Key words: strategic plan; stakeholder; crafted; pillars; elements; implementation; monitoring.

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Introduction

By any measure of modern management theory, no matter what the industry, the development and maintenance of a contemporary strategic plan through key stakeholder engagement is an absolute must for any organisation's long-term survival. Mintzberg, a well-known academic, advocates that an organisation's strategic plan must be crafted requiring 'a natural synthesis of the future, present and past'. [1,p75] This is to say, when developing its strategic plan the organisation must ensure the plan recognises

its past achievements and endeavours, accommodates the challenges presently facing it and articulates a future strategic framework, containing a comprehensive range of strategies, to ensure the risks it confronts in the future are mitigated.

The challenge is not listing the past achievements and endeavours of an organisation, or identifying the challenges presently facing it, but rather the real challenge is articulating the future strategic framework, containing a comprehensive range of strategies, to mitigate future risk. This article proposes such a comprehensive range of strategies will fall into six categories, which provide the framework for developing a comprehensive strategic plan. In keeping with Mintzberg's metaphor, for the purposes of this article these categories will be referred to as the six pillars around which a comprehensive strategic plan must be crafted.

If an organisation omits to articulate strategies in a particular pillar, it may result in a flawed strategic plan thereby weakening a robust risk mitigation strategy. Omitting essential strategies will prevent an organisation building on its strengths, prevent it from managing its weaknesses, result in opportunities not being optimised and mitigation strategies not being developed for threats to the organisation. The organisation's objective of having a structured framework for a cohesive approach for its performance and accordingly future proofing itself through the development of a strategic plan will, in all probability, not be realised.

Background

The author has had extensive senior heath executive and planning experience in various large and small healthcare settings. This article draws on this experience in presenting a comprehensive approach to strategic planning.

It was through the development of strategic plans subsequent to professional appointments that the author identified the six pillars and their importance in future proofing an organisation.

This article is focused on a comprehensive approach to strategic planning in the health industry and the six pillars referred to are as follows:

- **Corporate Governance**
- **Service Master Plan**
- **Facilities Master Plan**
- **Business Plan**
- **Clinical Governance**
- **Organisational Culture**

Discussion

Each of these pillars is now briefly discussed for the purposes of providing a definition and a considered rationale for inclusion as a pillar in a comprehensive strategic plan. When an organisation is developing its comprehensive strategic plan it will develop many futureproofing strategies. As each pillar is discussed, a number of elements are identified which are considered essential inclusions in this organisational future proofing process. Some elements will require strategy development, for example a fraud prevention strategy, some will require the development and adoption of a policy, for example an intellectual property policy, while other elements will simply require the development of a document or statement and its subsequent adoption, for example a mission statement. The board of an organisation and its executive are responsible for ensuring the elements identified for inclusion in its strategic plan are those which are required to ensure achievement of the organisation's future proofing objectives. The elements identified, while not discussed in detail in this paper, serve to provide a non-exhaustive range to be included in each pillar. Different organisations will require additional elements, while others will require less, depending on their organisation's life cycle. [2] The suggested required action is indicated against each element in each pillar as follows; strategy development (S); policy development (P); or development of a document or a statement (DS). This article discusses the organisation's responsibilities for the tracking of the required actions for each element in the section considering strategic plan monitoring.

Corporate governance

Corporate governance broadly refers to the mechanisms, processes and relations by which corporations are controlled and directed. 'It is a broad-ranging term which, amongst other things, encompasses the rules, relationships, polices, systems and processes whereby authority within organisations is exercised and maintained'. [3, p1]

The respective Australian, State/Territory Government Departments of Health together with Local Government regulate the health industry and their rules and regulations are highly complex. Strategies that assist an organisation to execute its governance responsibilities in compliance with relevant Acts and regulations as prescribed, together with compliance of relevant best practice industry governance standards, must be part of any organisation's strategic plan. To do otherwise in the high profile health industry may weaken the organisation's risk mitigation strategy through increasing the likelihood of non-compliance with

best practice governance standards. This could result in reputational damage to the organisation.

Fundamental elements for inclusion in this pillar:
- Philosophy/Mission/Vision/Values (DS)
- Legal Structure, Shareholder Agreement, By-laws (DS)
- Legislative/Regulatory compliance (S, DS, P)
- Corporate identity/branding (S)
- Board skills/ qualifications (S)
- Strategic Plan (S)
- Policies/procedures (P)
- Asset and Contract Registers (S)
- Instrument of Delegation (DS)
- External audit/ internal audit (S)
- Fraud prevention/ risk minimisation/insurance (S)
- Succession planning (S)
- Intellectual Property/Patents (DS)

Service master plan

An organisation must have elements in its strategic plan that ensure the services/products it provides to its customers are what they require. It is incumbent on an organisation to provide services to its customers that are relevant, safe, considered appropriate by the industry, meet customer 'wants' and 'needs' and recognise competitor service offerings.

In this article focusing on the health industry, the term customer is inclusive of patient, client and consumer and is used interchangeably. While the private health sector focuses on providing both what the consumer wants and needs, funding conditions in the public health sector require that resources are directed at providing health services which meet the client's health needs. For example cosmetic surgery is provided almost exclusively in the private health sector, therefore the service master plan must be reflective of the private/public health service context.

In both the private and public health sectors a contemporary service master plan is essential and forms the basis of all subsequent decisions in each of the following four pillars. Typically the service plan will be derived by the health organisation determining: its catchment population size and location; a complete and comprehensive demographic analysis of this population cohort both current and projected; the current health service utilisation from all health service providers, across all health conditions for this cohort; a projected health utilisation rate for this population cohort across all disease conditions, inclusive of comorbidities, utilising benchmark future demand

projection ratios and finally the current and projected private health insurance rates for the defined catchment population. The development and documentation of a comprehensive health service plan for any heath service provider is complex and a health organisation embarking on this process is strongly advised to engage the services of an experienced population health service planner.

Fundamental elements for inclusion in this pillar:
- Service range and level of service by location (S)
- Service differentiation (S)
- Market clearly defined (S)
- Market demographics/ analysis (S)
- Market share/penetration (S)
- Competitor analysis (S)
- Growth strategies (S)

Facilities master plan

In any service industry, the service provider must have facilities (buildings, equipment, IT and communications infrastructure) that will enable it to produce and deliver the services it has determined it will. This is particularly true in the health service provision industry. This is to say, structure follows function. In other words, once a health service provider has determined the services it will provide, it must determine the facilities it requires to ensure delivery of these services. Just as a health service provider's strategic plan must contain strategies that ensure a congruency between the organisation's service provision and its catchment population's demands, so to must it have strategies that ensure a congruency between service provision, facilities of operation and capacity.

The development of and documentation of a comprehensive health service facilities master plan for any heath service provider is extremely complex and a health organisation embarking on this process is again strongly advised to engage the services of experienced professionals such as an architect, quantity surveyor and information technology planner. With respect to information technology, communications and all equipment, consideration must be given to connectivity, capacity and integration. Again, it is recommended that expert advice be sought when making decisions in this regard.

Fundamental elements for inclusion in this pillar:
- Modern physical infrastructure and space (S)
- Building/property management, integrity, acquisition and maintenance (S)
- Environmental ambiance: grounds/internal (S)

- Contemporary IT infrastructure acquisition and maintenance (S)
- Contemporary telecommunications infrastructure (S)
- Modern vehicle fleet acquisition and maintenance (S)
- Modern functional equipment acquisition and maintenance (S)

Business plan

Once a health service provider has determined the services it provides to its catchment population and the facilities it requires to deliver these services, it is incumbent on the organisation to ensure it has strategies built into its strategic plan that provide for its ongoing financial sustainability and viability. This is the very heart of any business no matter what industry it is in, be it mining, retail, or the health industry. It is particularly so in the publicly funded health sector where the source of funding is taxpayers dollars, which can be negatively impacted by public policy. It is strongly emphasised here that the business performance strategies contained in a health service provider's carefully crafted comprehensive strategic plan, must ensure that the health service remains financially viable. The organisation must not only ensure that its annual operational targets are achieved within budget, but that all elements of its strategic plan are subjected to a cost-benefit analysis. This analysis must in turn be used to inform the strategic plan decision-making processes with respect to choice of options within each element and the pursuit of priority elements across the pillars in any given period.

Fundamental elements for inclusion in this pillar:
- Business growth/ sustainability/ competitive (S)
- Business profitability/budget compliance (S)
- Culture of business soundness/acumen (S)
- Robust financial ratios (S)
- Robust financial analysis/ reporting/monitoring (S)
- Workforce/HR/ OH&S/ industrial frameworks (S)
- Organisation structure/ reporting lines (S)
- Robust IT software systems- acquisition and maintenance (S)

Clinical governance

Clinical governance is a systematic approach to maintaining and improving the quality of the services received by an organisation's customers. 'Clinical Governance is, at its core, about being accountable for providing good, safe care to patients and its fundamental continuous improvement to patient safety' [4, p1] Strategies that ensure compliance with relevant Acts and regulations as prescribed, together with compliance of relevant best practice industry

clinical governance standards must be part of any health organisation's strategic plan. To do otherwise in a health organisation's high profile industry would, just as in corporate governance, be equally if not more potentially catastrophic in this area. The health industry is unique as it has responsibility in clinical governance as well as corporate governance, and accordingly, a health organisation's strategic plan must contain strategies that mitigate against clinical/quality risk. These quality strategies must not only apply to direct clinical service provision but all decision-making processes in the organisation relating to an organisation's corporate governance, its facilities and business performance as well. Health services must foster a culture of Continuous Quality Improvement throughout the entire organisation and work to achieve industry best practice in every pillar of its comprehensive strategic plan. As Deming has said, 'Quality has to be designed and built into the product; it cannot be inspected into it'. [5, p3]

Fundamental elements for inclusion in this pillar:
- Clinical governance framework [S]
- Clinical governance plan [S]
- Legislative/Regulatory compliance (S, DS, P)
- Robust clinical indicators [S]
- Participation in the relevant industry accreditation program [S]
- Continuous quality improvement program [S]
- Staff credentialing and defining scope of practice monitoring [S]
- For non-clinical staff, skills and qualifications up to date [S]
- All staff participate in continuing professional development [S]
- Consumer participation (S)
- Contractors accredited and managed in accordance with Work Health & Safety legislation [S]
- Clinical risk/assessment/management program and register (S)

Organisation culture

'Organisational culture is the shared values and beliefs that guide how members of an organisation approach their work and interact with each other'. [6, p4] An organisation must monitor and adopt strategies that influence the culture it aspires to have and which underpin the objective of future proofing the organisation. For example it is the author's view that just as quality must permeate every facet of an organisation, so too must an organisation respond promptly to every decision-making aspect of its business in a timely

way. Whether this is to patient/client issues or any issue in any of the strategies identified in any of the six pillars of its comprehensive strategic plan, a health service provider must foster a timely decision-making process as a way of doing business from the bottom up of the organisation. Not to do so will pose a threat to achieving the targets of an organisation's strategic plan, its entire performance and ultimately its Purpose, Mission and Vision.

The elements in this pillar have been included, in the author's view, for their positive effect on organisational culture and ultimately, its future proofing. In so doing there will be an inherent link in the organisation's strategic plan with its leadership, quality and innovation values, its commitment to safety and to consumer outcomes.

Fundamental elements for inclusion in this pillar:
- Continuous Quality Improvement culture [S]
- Lean Thinking culture [S]
- Customer focus culture [S]
- Responsive culture [S]
- Embracing of change [S]
- Monitoring opportunities and threats [S]
- Staff reward/recognition program [S]
- Research and Development [S]
- Use of relevant media-social media [S]
- Website that links the organisation's internal and external environments [S]
- Service benchmarking [S]

In crafting its comprehensive strategic plan it is imperative that the governing body and its executive take time out to make the necessary decisions, synthesising the past and the present, to 'craft' the future plan as advocated by Mintzberg. It is further recommended that a stakeholder engagement program, as discussed below, is developed and actioned by the health service provider and that this entire process be facilitated by an experienced strategic planner, including its documentation.

At the conclusion of the strategic planning process, the identified strategies must be documented in one comprehensive strategic plan and separated into the six pillars referred to above.

Additional considerations
There are five key additional considerations that must be made during the development or crafting and implementation of a health service organisation's comprehensive strategic plan. These are identified and discussed in turn below.

• *Multi-site organisation:*
In view of the ongoing consolidation of health services, the number of multi-site organisations is only going to increase in the future. Typically the hub and spoke model of health service delivery will become the norm. For the consumer this will see as many services as affordable and safe to do so, continue to be provided close to home. For the health provider this model of care must be reflected in all pillars of its strategic plan.
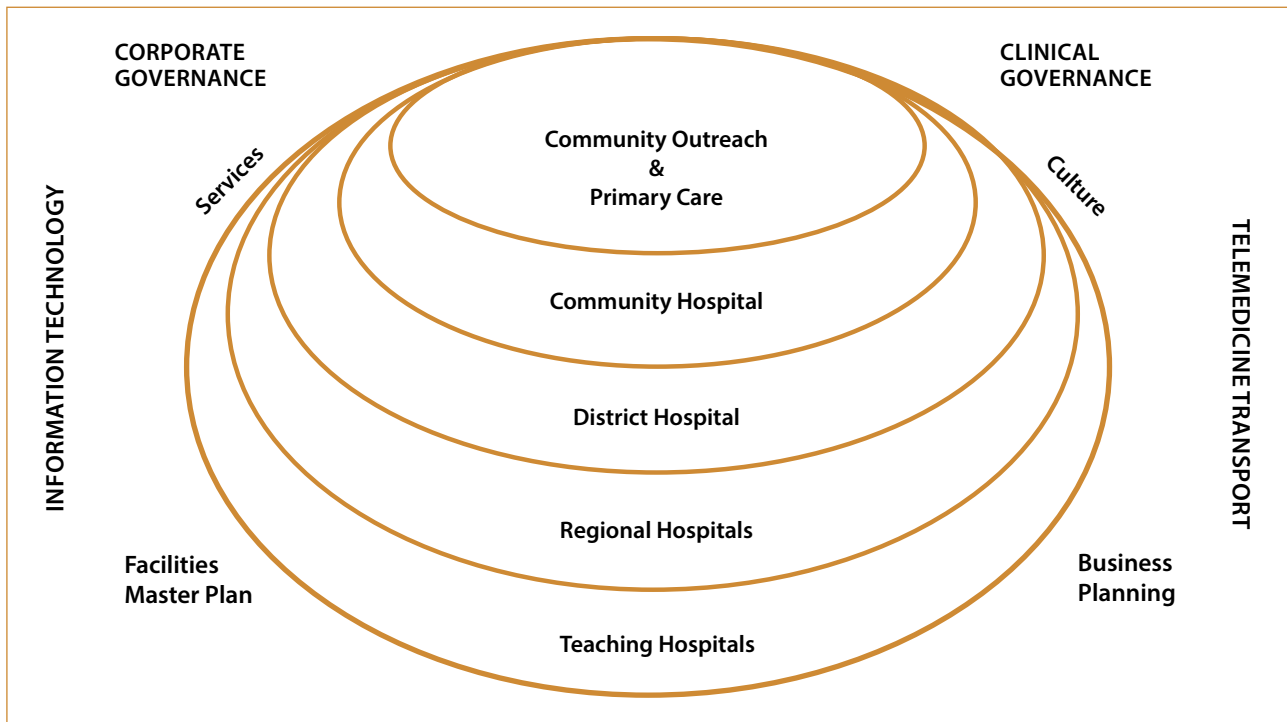
• *Functional integration:*
In becoming a truly multi-site organisation, health service providers must ensure that they operate efficiently and do not duplicate any corporate/quality functions, administrative or supervisory roles in their structures or any business/ service delivery through the implementation of their comprehensive strategic plan. They must remain vigilant to insure that the maximum economies of scale are derived in the implementation of their plan. The strategies arising from the elements within each of the pillars must again reflect one comprehensive approach for the entire organisation.

Examples include: one comprehensive orthopaedic service plan inclusive of all sites of the organisation within the service master plan pillar, detailing the type and complexity or level of each orthopaedic service to be provided at each site; one comprehensive IT infrastructure strategy inclusive of all sites of the organisation within the facilities master plan pillar; one comprehensive workforce plan inclusive of all sites of the organisation within the business plan pillar; one comprehensive staff credentialing and scope of service monitoring plan across all sites of the organisation.

This is to say all the functions/responsibilities of the health service provider must be applied throughout the entire organisation so as to ensure it operates as one single entity and its stakeholders/customers/clients experience a linked, functionally integrated service at all times. The organisation must do this for its clients, not the clients for the organisation. [7] The author has observed that the root cause of a statistically significant number of adverse events in the health industry is systems and processes not being functionally integrated. In undertaking a root cause analysis for an adverse event, how often have we heard the final result being summarised, figuratively speaking, as 'the patient/client simply fell between the cracks'. Health service providers must also implement their comprehensive strategic plans in such a way so as to foster the functional integration of their service provision.

Figure 1: Functional Integration Model

Functional integration of multi-site health services may be represented diagrammatically in the acute sector by Figure 1. An extended version would include multi-purpose service, mental health and aged care and other services.

• *Resource requirements:*
Strategic plans contain a significant body of work, that when implemented will derive significant long lasting accrued benefits to the organisation.

Organisations should consider responding to their strategic plan's inherent challenges by viewing the plan's implementation as an investment in its future viability and invest in this implementation accordingly.

• *Implementation:*
A strategic plan's implementation must be an inherent consideration of its development. The rationale for this is that an organisation's adopted strategic plan must be fully implemented, anything less will ultimately compromise the objectives of undertaking its development. In the author's experience the best way to get stakeholders engaged with the strategic plan's implementation is to engage them in its development.

With the knowledge that 'people support what they help create' the objective for an organisation must be to keep all key stakeholders engaged not only through the plan's development but also through its implementation. At the outset of commencing the development of an organ-isation's crafted comprehensive strategic plan, a stakeholder engagement program must be adopted with the end game of the plan's implementation in mind. The benefits of this engagement therefore become twofold. The quality of the plan itself is enhanced as a result of this engagement as is the plan's implementation.
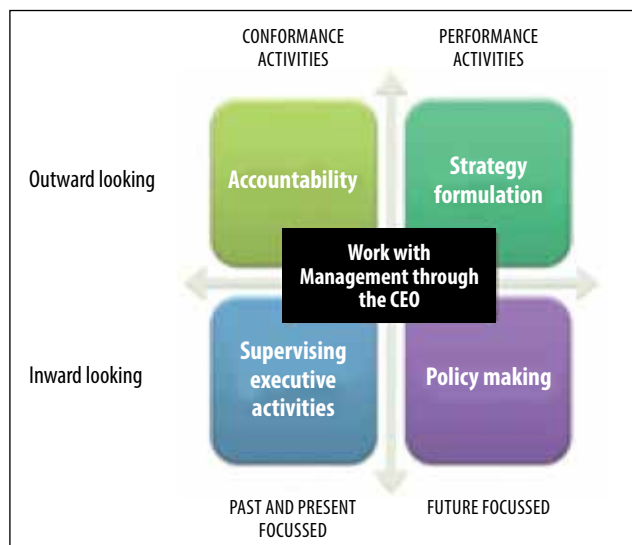
• *Monitoring the strategy:*
High performing boards have the oversight of all strategies as a priority. The capacity of a board and its executive to drive strategic plan implementation and the changes that come with this enables a business to stay competitive and continue to grow. What really matters is the staff are lined up to implement the strategy. [8] For a health service organisation this oversight is fundamental for all pillars of the comprehensive strategic plan.

The Australian Institute of Company Directors emphasises that there are two key areas of monitoring responsibility for boards in the performance of the company: the overall strategic performance and the overall compliance performance. [9] At times this dual monitoring role could be seen as challenging, but at the end of the day it is a responsibility that must be executed.

The Tricker framework (Fgure 2) designed by Bob Tricker [10] demonstrates the performance and compliance dilemma that a Board Director grapples with in undertaking the duties of directorship.

Figure 2: Tricker Framework [10]

Figure 3: The KPI Cycle

It is recommended that all boards, no matter the industry, utilise a strategic plan monitoring tool to assist it in the execution of this critical governance pillar. A tool that stimulates the board to ask the questions focused on the exceptions to the strategic outputs is a must. In doing so, the board is able to enquire of the CEO the reasons for the lag times in the strategic implementation and identify ways of providing resources to the executive team to get the strategic actions back on track.

The monitoring tool concept fits within the performance activities related to monitoring strategy formation and future focus. It is also to be noted that a key strategy in implementation is the integration with existing information systems and keeping the system simple so that the concept, such as clinical governance, is embedded. [11]

The failure of HIH Insurance gave rise to an extensive set of recommendations by Justice Neville Owen who made reference to endorsed strategy. 'Lack of attention to detail, lack of accountability for performance, and a lack of integrity in the company's internal processes and systems. The monitoring of the strategic plan is essential in setting the culture of performance monitoring across the organisation.' [12, p3]

This article suggests that the linking of all business plans to strategy can be connected through the strategy implementation actions. The link to strategy drives the organisation to successful strategy outcomes. It is a discipline that keeps management on track and assists it to keep staff on track with the focus always being on the set strategy.

For the strategic plan to be implemented successfully it must be embedded at all levels of the organisation. This includes

input to the plan as referred to above in key stakeholder engagement and monitoring of the strategic actions. This process can occur at monthly meetings using a monitoring tool (Figure 3), a process that should be a feature of all direct report meetings; executive managers to CEO; middle managers to executive managers; unit managers to middle managers. If the organisation fails to monitor, it plans to fail. Essentially, if the actions are not in the strategy they won't get done, if the staff are undertaking work that isn't linked to the strategy, it shouldn't get done. There must be a congruency of strategies between the individual, the team and the organisation.
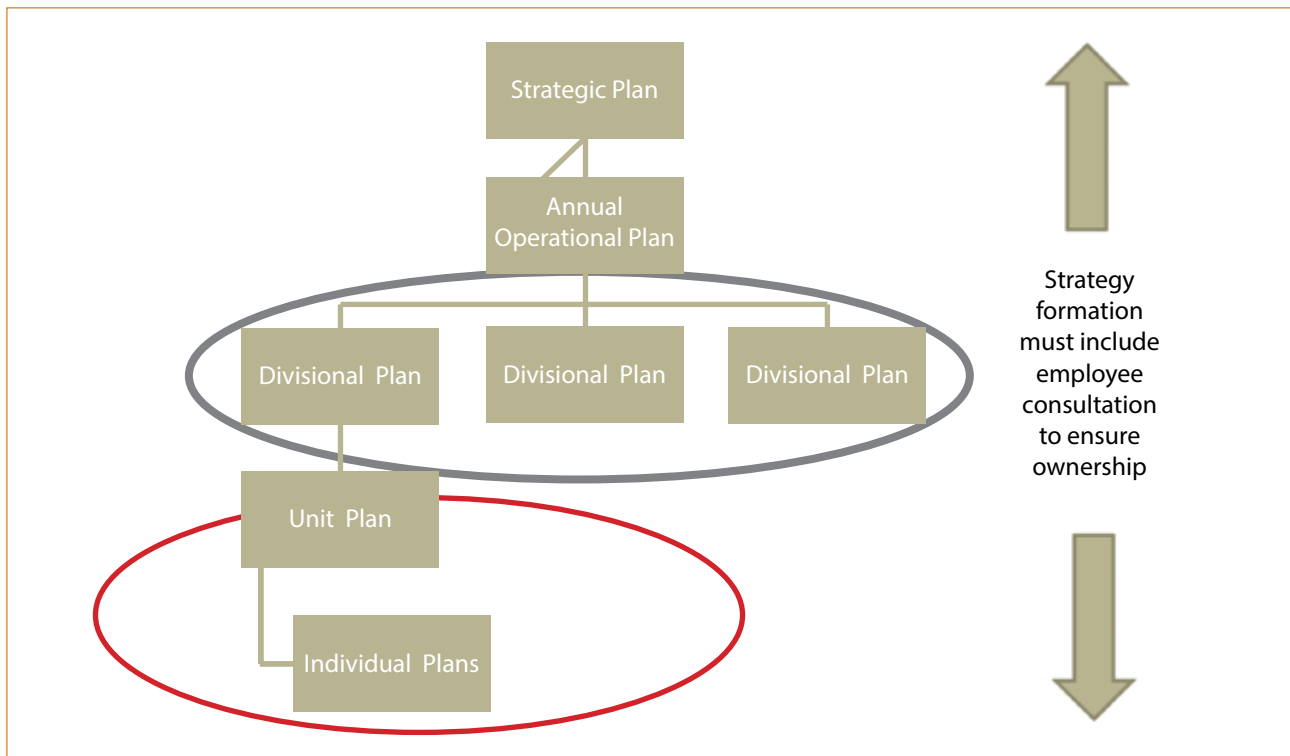
The board sets the strategies, the executive designs the strategy actions and the board needs the red flags in the monitoring system to investigate if further resources are required.

Managers and direct reports tracking the progress together direct all resources directed towards a successful outcome.

These strategies need to cascade by devolving responsibility for aspects of the strategic plan at various levels of the organisation. [13] (Figure 4) The annual operational plan is distributed to the divisional executive managers who have responsibility for designing their response to the strategies and placing responsibility with middle managers/team leaders and unit managers. In addition, this is supported by key performance indicators (KPIs) being included in individual performance plans.

The key message is that the monthly review at all levels is critical, as this reduces poor performance against the strategic plan.

Figure 4: Cascading strategies

This ensures that the CEO and the executive are assisted in their role of implementing the strategic plan for the board.

It is always a challenge to link the strategic intent, as expressed by the Strategic Plan, with the annual operational activities of the organisation. By using a monitoring tool, referencing strategies in monthly direct report meetings and reporting quarterly to the board, strategic activities can be quickly identified as lagging, in progress or met. If an action is lagging a red flag highlights this issue. The board's role is to 'oversee performance and compliance. Directors must put in place systems and processes to control and monitor- 'or govern'- the organisation.' [14]

Conclusion plan

The crafting of a contemporary strategic plan with six inherent pillars through key stakeholder engagement is fundamental for any organisation's long-term survival. The rationale for their inclusion is outlined and discussed, and representative strategies within each pillar are identified. This article has also identified and discussed the key issues of multi-site and functional integration challenges, resource implications, implementation needs and monitoring requirements as crucial in ensuring the successful implementation of such a strategic plan.

Through the development and successful implementation of a strategic plan as referred to, a health service organisation will have significantly greater confidence that the risks it confronts in the future are mitigated. A health service's board and its executive would have every justification to be optimistic of their ability to future proof the organisation when adopting the strategic planning approach discussed in this article.

As Benjamin Franklin said, 'If you fail to plan, you are planning to fail'. [15, p1]

Competing Interests

The author declares that he provides a strategic planning service as a consultant to organisations, including the health sector.

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It's Time: the poor culture regarding safety and quality in Australian hospitals must be addressed!

E Davis and N Beale

Abstract

This review article demonstrates the causal relationship between a poor safety and quality culture in Australian and overseas hospitals and the occurrence of adverse patient events (AEs). The evidence of serious adverse events occurring in these hospitals is unquestionable.

Awareness of the importance of that poor safety and quality culture in hospitals and its linkage with AEs is not as widespread as is warranted, but there is mounting evidence of its rapidly increasing recognition. The concept of technical and non-technical competence in workers in different industries is also well developed, with an increasing consensus that the non-technical aspects of healthcare delivery are responsible for a majority of the adverse events, rather than issues of technical competence.

The need to provide patient safety education, particularly in a multi-professional setting has been established through the World Health Organisation's (WHO) *Patient Safety Curriculum Guide: Multi-Professional Edition* in 2011. This document also stresses the importance of multi-disciplinary care teams. A corollary of this is the need to extend this education to more senior members of healthcare teams, who did not experience these concepts in their education.

Following completion of the education of those senior members in the issues of a safety and quality culture, all members of those professions must then have periodic mandatory reviews of these lessons incorporated into their continuing professional development (CPD) activities.

One manifestation of that poor safety and quality culture is bullying, which is extensive in hospitals and which is rapidly being recognised in the Australian environment.

Abbreviations: ACSQHC – Australian Commission on Safety and Quality in Health; AE– Adverse Events; ASPEF – Australian Safety Patient Education Framework; CPD – Continuing Professional Development; CRM – Crew/Crisis Resource Management; NHS – National Health Service; QAHCS – The Quality in Australian Healthcare Study; WHO – World Health Organisation.

Key words: adverse events; bullying; crisis resource management; culture; non-technical competence; quality; safety.

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Introduction

There are those who are either unaware of the poor safety and quality culture in the Australian healthcare sector, or choose to believe that it is exhibited in only some organisations. This denial attitude is outdated, with evidence of serious adverse events (AEs) being shown in Australia 20 years ago. [1]

This review article will demonstrate the extent of the AEs in patients admitted to hospitals in Australia and overseas and the linkage of many of those AEs with poor safety and quality cultures.

The earliest recognition of the importance of cultural aspects of interpersonal relationships in complex work environments occurred in the Aviation industry in the 1980s and 90s. From here came crew resource management (CRM). The resulting reduction in aircraft crashes soon led to CRM being modified and introduced into healthcare, particularly in those areas in health with a high intensity of activity, such as intensive care units, emergency departments, theatre and labour wards. [2,3,4]

The recognition that the non-technical skills of individual team members are more relevant than technical ones was an important step in the evolving successful use of cultural factors in improving safety and quality. [5,6,7] One important manifestation of poor culture in healthcare is bullying, which is widespread.

Adverse events in hospitals

The large number of AEs affecting patients of Australian hospitals was first raised in 1995 by Wilson et al in their article 'The Quality in Australian Healthcare Study' (QAHCS). [1] Their definition of an AE was (1) an unintended injury or complication which (2) results in disability, death or prolongation of hospital stay, and is (3) caused by healthcare management issues rather than the patient's disease.

The conclusion reached was that 16.6% of admissions were associated with an AE, with half of these being preventable and that of all AEs, 18.5% resulted in permanent disability or death. The death rate was estimated to be 4.6%.

In 1999 an analysis of the causes of adverse events (AE), identified in the QAHCS, was published by Wilson, et al. [8] After discussion of the statistics about the causes of the errors, the conclusion was reached that cognitive failure appears to have a role in 57% of all the causes of AEs and that fifty percent of the AEs were judged to have a high preventability score.

In 2000 the Institute of Medicine in the United States published its seminal paper – 'To Err is Human: Building a Safer Health System'. [9] This report estimated that between 44,000 and 98,000 patients died in American hospitals every year as a result of medical errors. In the authors' opinion the majority of medical errors were not the fault of any group, but rather due to poor systems and processes in providing care.

A 2000 report from the United Kingdom showed that medical errors caused adverse events annually in an estimated 850,000 admitted patients to the National Health Service (NHS). [10] This represented 10% of patients. Included in the executive summary is the comment that a barrier in achieving active learning from past failures is organisational culture. A safety culture is the preferred model.

The Australian Institute of Health and Welfare collects and publishes annually the incidence of AEs for all public and private hospitals. For the 2013/14 year the figure of recorded adverse events has passed the half a million event mark for the second time, now being 47.6% greater than the figures recorded in the 2006/07 year. [11] This change happened within the backdrop of extensive encouragement and indeed demands from accreditation bodies, State Departments of Health, Insurers and National Bodies such as the Australian Commission on Safety and Quality in Healthcare (ACSQHC).

The Mid Staffordshire NHS Foundation Trust was subject to a series of inquiries from 2008, following public outcry about the poor quality and safety of patient care in their hospitals. These commenced in early 2008, with the definitive report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC, being released in three volumes in March 2013. [12]

The report has a chapter discussing the prevailing negative culture and comments that this must be changed to a positive safety culture.

The Berwick Report, chaired by Professor Don Berwick, was published in August 2013. [13] Berwick was commissioned by the British Government to consider the recommendations from the Francis report and the NHS overall.

In the first Recommendation the report stated:
Patient safety should be the ever-present concern of every person working in or affecting NHS-funded care. The quality of patient care should come before all other considerations in the leadership and conduct of the NHS, and patient safety is the keystone dimension of quality.

Culture in healthcare

Recognition of the importance of cultural issues, including cognitive or non-technical aspects of performance, occurred in much the same time frame in Australia as overseas. In contrast however the adoption of developments in safety and quality management using that information, seems to have occurred more slowly in Australia when compared with the United States, Canada, the United Kingdom and other European countries.

In 2005 a paper by Leape and Berwick was published in the *Journal of the American Medical Association* – 'Five years after To Err is Human: What have we learned'. [14] While they were disappointed in what had been achieved in those

five years, they did acknowledge that the groundwork had been established in hospitals with many more groups and professional bodies actively looking at the improvement of safety. There was still concern expressed in the ongoing propensity of some to decry the benefits of a system approach to safety, preferring to use the old 'blame culture'.

The Victorian Department of Health's 2008-2009 Report on Sentinel Events shows that 20% of the events were identified as being due to communication issues, sentinel events being the most severe types of AEs. [15]

The American Joint Commission in its 2007 Annual Report on Quality and Safety, states on page 46, that inadequate communication between care providers or between care providers and patients/families is consistently the main root cause of sentinel events. [16]

In his two-part perspective, 'A Culture of Respect, Part One: The Nature and Causes of Disrespectful Behaviour by Physicians' and 'A Culture of Respect, Part Two: Creating a Culture of Respect', [17,18] Professor Lucian Leape writes powerfully on the dysfunctional culture of doctors towards others in the healthcare field and how, in his opinion, it is essential to have a culture of respect that will allow the development of a better culture in healthcare.

It is not our view or experience that doctors are the only group involved in disrespectful behaviour. To a greater or less degree, disrespectful behaviour occurs in all professional and non-professional groups in hospitals. That, we suggest, is an underlying cause of much of the problem in the safety and quality culture within healthcare.

The NHS paper, 'An Organisation with a Memory', comments on the list of barriers to organisational learning. [10, p.34] Of the 14 factors listed, virtually all relate to culture. Examples of some of these are – rigidity of core beliefs; ineffective communication; a tendency towards scapegoating; and people being unwilling to learn from negative experiences.

Bullying

There are extensive references in the literature to bullying in healthcare.

A recent topical event vividly demonstrating this problem has been the revelation of alleged sexual harassment of female surgical trainees by surgeons. This surfaced publicly in March 2015, resulting in the decision of the Royal Australasian College of Surgeons to hold an inquiry into the issue, chaired by Mr Rob Knowles, former Victorian Health Minister.

An early source on this topic is the article by L Quine on workplace bullying in NHS community trusts. [19] The survey showed 38% of the staff reported being subjected to bullying, while 42% had witnessed bullying of others.

In the 2005 report of the Victorian Taskforce on Violence in Nursing, the Chair advised the Minister that nurses are frequently exposed to occupational violence and bullying. [20] Nurses are also exposed to bullying within the workplace from other health professionals, supervisors and from their nursing peers. Twenty-nine recommendations were made.

In Victoria, the Public Sector Commission considers even a single incident of disruptive treatment of a member of staff as bullying, while in most jurisdictions the legal definition of bullying includes the requirement that the disruptive activity must consist of repeated episodes. [21] Regardless of legal definitions the important factor to consider is the effect on the recipient and the subsequent downstream events that may follow.

The Victorian Public Sector Commission has been conducting People Matter Surveys of the non public servant employees in the Victorian Public Sector for over a decade. Its publication 'Trends in Bullying in the Victorian Public Sector – People Matter Survey 2004 – 2010' shows that the percentage of respondents reporting bullying was 21 per cent. This varies substantially in different parts of the sector. The health sector has the highest average (26 per cent) and the water sector has the lowest (13 per cent). [22]

The concept of horizontal violence, i.e. bullying of nurses by other nurses, is a well known phenomena and stated to be the second most common form of bullying experienced by nurses. [23, 24] The effects on the bullied nurse and its wider ramifications of disengagement with reduction of productivity and patient care are also stated.

In its 2014 annual report of the National Training Survey on bullying and undermining of doctors in training the General Medical Council of the United Kingdom showed that 8% of doctors in training had experienced bullying, while another 13.6% had witnessed bullying. [25]

This program began in 2006, when the perceived rate of bullying of doctors in training was 16.5%, but the incidence of witnessing bullying was not surveyed. Specialty registrars reported that the source of 70% of their bullying was consultants, and less than 10% from nurses or midwives.

In its Sentinel Event Alert number 40, the Joint Commission in the United States discusses behaviors that undermine a culture of safety. [26] The report assesses the damage that

can be caused by intimidating and disruptive behaviours by fellow workers. It claims this can foster medical errors and contribute to preventable AEs, as well.

Additional excellent information about the consequences of bullying and suggestions as to mechanisms to counter the problem can be found in the papers by Porto and Lauve, and Rosentstein and O'Daniel. [27,28]

What does the evidence show regarding improvement in patient outcomes?

A review of articles on changes in the quality and safety of patients in overseas hospitals from the implementation of cultural modification techniques, shows some significant achievements, but also the need for further studies for confirmation. [29,30,31,32,33]

The major reason advanced for the reserve expressed in the literature is the variability in the composition of many of the trials discussed, with solid proof still to be shown. Nonetheless this paper asserts that the tipping point has been reached and more widespread corrective action should ensue.

The Agency for Healthcare Research and Quality in its publication Number 211, *Making Healthcare Safer II* provides some focus on team training. [34]

This updated critical analysis of the evidence for patient safety practices as shown by extensive systematic reviews was published in March 2013. Chapter 40 describes the analysis on team training in healthcare. Team training, was said to have become 'an overarching term that encompasses a broad range of learning and development strategies, methods and teamwork competencies'. These are factors underlying effective teamwork, which 'differentiates team-training activities from technical or procedural learning activities'. In other words the non-technical cultural factors discussed previously. These include communication, situational awareness, leadership, role clarity and co-ordination.

In the summary in that chapter is the statement that the implementation of team-training programs has been associated with improvements in patient safety outcomes (e.g. reductions in adverse events, reductions in mortality). [35, 36]

The most outstanding results are shown in the study by Neily et al, of the effectiveness of a medical team training program in reducing surgical mortality rates in the Veterans Health Administration hospitals. [37] Of their 108 facilities,

74 participated in the training program, while the 34 other facilities were the control group. The test hospitals had an 18% reduction in their annual mortality rate in those undergoing surgical procedures, while the control group had a 7% reduction in their mortality rate.

What is happening in Australia?

While it is suggested that the rate of recognition of the cultural issues behind the poor safety culture in Australian healthcare has been slow, there are areas of exception to that proposition. Overall a better description of the rate of acceptance would be intermittent. Considerable success has been shown in acute areas of hospitals, such as emergency departments, theatre, labour wards and intensive care units.

An important initiative was the development of the national patient safety education framework for Australia by ACSQHC. [38]

From that activity came the detailed Australian Patient Safety Education Framework (APSEF). [39] Professor Barraclough, Chair of the Council, comments that the framework provides a simple, flexible and accessible Framework that identifies the knowledge, skills, behaviours, attitudes and performance required by all healthcare workers in relation to patient safety.

Subsequently in 2009, the World Alliance for Patient Safety launched the WHO *Patient Safety Curriculum Guide* for medical schools. Although this was developed substantially from the APSEF, it was interesting that while WHO guide was for medical schools, the APSEF was designed to be used by all health professions.

This anomaly was rectified by the subsequent creation by WHO of the Patient Safety Curriculum Guide – *Multi-Professional Edition*, 2011. [40] In this document the Director-General of WHO and the leaders of the World Associations in Dentistry, Medicine, Midwifery, Nursing and Pharmacy endorsed the principles of patient safety contained in the guide and commented on the importance of multi-disciplinary education and multi-disciplinary care teams.

The principles in the guide are suitable to be adapted into the curricula for all other health professionals

In Medicine, the websites of the Australian and New Zealand College of Anaesthesia (www.anzca.ed.au), the Australasian College for Emergency Medicine, (www.acem.org.au) and the Royal Australasian College of Surgery (www.surgeons.org) show how those colleges incorporate team training (CRM) in their education activities for candidates for Fellowship.

In Queensland Health a maternity crisis resource management program was developed in response to the report on the outcomes of the maternity review. [41] The follow-up of participants indicated that all recommended that future programs should be inter-disciplinary, not least because it related to the situation in the real world and enabled the growth of empathy.

An article by Gillon et al, explains why medical emergency team intervention differs from traditional ward-based doctor-patient encounters, and emphasise the importance of non-technical skills during the medical emergency team response. [42]

In their article 'Integrating the Science of Team Training: Guidelines for Continuing Education', Weaver et al, point out that the provision of high-quality, efficient care results from the coordinated, cooperative efforts of multiple technically competent healthcare providers working in concert over time, spanning disciplinary and professional boundaries. [43] They further comment that teamwork skills are vital to provide safe patient care.

The article also observes that while the education of younger doctors now includes this experience, longer serving practitioners have not learnt this aspect of behaviour. They should therefore have initial and ongoing training in their continuing professional education to develop the attitudes, behaviors (skills), and cognitive knowledge necessary for highly reliable and effective team performance.

Weaver et al also show that communication, partnership and teamwork are identified as core domain competencies by regulatory agencies in Europe, the American Medical Association, the Medical Council of Canada and the Medical Board of Australia.

Accentuating the interdisciplinary nature of excellent healthcare, Ponte et al point out that underlying this push for greater interdisciplinary collaboration is the premise that safety, quality, and efficiency in patient care delivery is bolstered by structures and processes that equalise the status of clinicians on the care team, and that promote interdisciplinary collaboration and teamwork, while reducing or eliminating traditional hierarchical systems and cultures. [44]

An issue in Australia is that if the education of developing healthcare professionals continues to be provided in separate silos, the tasks of integrating those independent professionals in their working life will be that much more difficult.

At Southern Health in Melbourne, TeamSTEPPS ® from the American Agency for Health Research and Quality, which is a CRM-based activity, is taught to a wide range of staff, but it is also used in the undergraduate curriculum. [45]

Provonost et al give a fascinating view of their plan to ensure the safety and quality of the care given to their patients in core processes of care at John Hopkins Medicine. [46]

Conclusion

This study has shown the continuing serious level of AEs in the Australian healthcare sector and that a significant element of that problem is the persistent poor safety and quality culture.

While evidence on the efficacy of crisis resource management techniques in correcting the poor safety and quality culture, and reducing AEs is not conclusive, there is enough evidence to encourage its greater use, review the outcomes and make modifications in accordance with the results.

Of great importance is the need to ensure interprofessional collaboration and teamwork of all our health professional groups, by implementing the WHO Patient Safety Curriculum Guide – Multi-Professional Guide 2011. [40] It must not be forgotten that the current group of health professionals will need to learn these techniques through their Colleges, Associations and obligations to their regulatory bodies in their CPD activities. To be effective, this process must become a mandatory component of those CPD activities.

This study challenges culture change at all levels to reduce the ever-increasing number of AEs/deaths.

Competing interests

The authors declare that they have no competing interests.

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Further information about the Vancouver referencing style can be found at http://www.bma.org.uk/ap.nsf/content/LIBReferenceStyles#Vancouver

Types of Manuscript - some general guidelines

1. Analysis of management practice (eg, case study)

Content

Management practice papers are practitioner oriented with a view to reporting lessons from current management practice.

Abstract

Structured appropriately and include aim, approach, context, main findings, conclusions.

Word count: 200 words.

Main text

Structured appropriately. A suitable structure would include:

- Introduction (statement of problem/issue);
- Approach to analysing problem/issue;
- Management interventions/approaches to address problem/issue;
- Discussion of outcomes including implications for management practice and strengths and weaknesses of the findings; and
- Conclusions.

Word count: general guide - 2,000 words.

References: maximum 25.

2. Research article (empirical and/or theoretical)

Content

An article reporting original quantitative or qualitative research relevant to the advancement of the management of health and aged care services organisations.

Abstract

Structured (Objective, Design, Setting, Main Outcome Measures, Results, Conclusions).

Word count: maximum of 300 words.

Main text

Structured (Introduction, Methods, Results, Discussion and Conclusions).

The discussion section should address the issues listed below:

- Statement of principal findings;
- Strengths and weaknesses of the study in relation to other studies, discussing particularly any differences in findings;
- Meaning of the study (eg implications for health and aged care services managers or policy makers); and
- Unanswered questions and future research.
  Two experienced reviewers of research papers (viz, Doherty and Smith 1999) proposed the above structure for the discussion section of research articles. [2]

Word count: general guide 3,000 words.

References: maximum of 30.

NB: Authors of research articles submitted to the APJHM are advised to consult 'Writing a research article: advice to beginners' by Perneger and Hudelson (2004) and available at: <http://intqhc.oxfordjournals.org/cgi/content/full/16/3/191> This article contains two very useful tables: 1) 'Typical structure of a research paper' and 2) 'Common mistakes seen in manuscripts submitted to this journal'. [3]

3. Research note
Content
Shorter than a research article, a research note may report the outcomes of a pilot study or the first stages of a large complex study or address a theoretical or methodological issue etc. In all instances it is expected to make a substantive contribution to health management knowledge.

Abstract
Structured (Objective, Design, Setting, Main Outcome Measures, Results, Conclusions).
Word count: maximum 200 words.

Main text
Structured (Introduction, Methods, Findings, Discussion and Conclusions).

Word count: general guide 2,000 words.

As with a longer research article the discussion section should address:
- A brief statement of principal findings;
- Strengths and weaknesses of the study in relation to other studies, discussing particularly any differences in findings;
- Meaning of the study (eg implications for health and aged care services managers or policy makers); and
- Unanswered questions and future research.

References: maximum of 25.

NB: Authors of research notes submitted to the APJHM are advised to consult 'Writing a research article: advice to beginners' by Perneger and Hudelson (2004) and available at: <http://intqhc.oxfordjournals.org/cgi/content/full/16/3/191> This article contains two very useful tables: 1) 'Typical structure of a research paper' and 2) 'Common mistakes seen in manuscripts submitted to this journal'. [3]

4. Review article (eg policy review, trends, meta-analysis of management research)
Content
A careful analysis of a management or policy issue of current interest to managers of health and aged care service organisations.

Abstract
Structured appropriately.
Word count: maximum of 300 words.

Main text
Structured appropriately and include information about data sources, inclusion criteria, and data synthesis.

Word count: general guide 3,000 words.

References: maximum of 50

5. Viewpoints, interviews, commentaries
Content
A practitioner oriented viewpoint/commentary about a topical and/or controversial health management issue with a view to encouraging discussion and debate among readers.

Abstract
Structured appropriately.
Word count: maximum of 200 words.

Main text
Structured appropriately.
Word count: general guide 2,000 words.

References: maximum of 20.

6. Book review
Book reviews are organised by the Book Review editors. Please send books for review to: Book Review Editors, APJHM, ACHSM, PO Box 341, NORTH RYDE, NSW 1670. Australia.

Covering Letter and Declarations
The following documents should be submitted separately from your main manuscript:

Covering letter
All submitted manuscripts should have a covering letter with the following information:
- Author/s information, Name(s), Title(s), full contact details and institutional affiliation(s) of each author;
- Reasons for choosing to publish your manuscript in the APJHM;
- Confirmation that the content of the manuscript is original. That is, it has not been published elsewhere or submitted concurrently to another/other journal(s).

Declarations

1. Authorship responsibility statement

Authors are asked to sign an 'Authorship responsibility statement'. This document will be forwarded to the corresponding author by ACHSM on acceptance of the manuscript for publication in the APJHM. This document should be completed and signed by all listed authors and then faxed to: The Editor, APJHM, ACHSM (02 9878 2272).

Criteria for authorship include substantial participation in the conception, design and execution of the work, the contribution of methodological expertise and the analysis and interpretation of the data. All listed authors should approve the final version of the paper, including the order in which multiple authors' names will appear. [4]

2. Acknowledgements

Acknowledgements should be brief (ie not more than 70 words) and include funding sources and individuals who have made a valuable contribution to the project but who do not meet the criteria for authorship as outlined above. The principal author is responsible for obtaining permission to acknowledge individuals.

Acknowledgement should be made if an article has been posted on a Website (eg, author's Website) prior to submission to the Asia Pacific Journal of Health Management.

3. Conflicts of interest

Contributing authors to the APJHM (of all types of manuscripts) are responsible for disclosing any financial or personal relationships that might have biased their work. The corresponding author of an accepted manuscript is requested to sign a 'Conflict of interest disclosure statement'. This document will be forwarded to the corresponding author by ACHSM on acceptance of the manuscript for publication in the APJHM. This document should be completed and signed and then faxed to: The Editor, APJHM, ACHSM (02 9878 2272).

The International Committee of Medical Journal Editors (2006) maintains that the credibility of a journal and its peer review process may be seriously damaged unless 'conflict of interest' is managed well during writing, peer review and editorial decision making. This committee also states:

'A conflict of interest exists when an author (or author's institution), reviewer, or editor has a financial or personal relationships that inappropriately influence (bias) his or her actions (such relationships are also known as dual commitments, competing interests, or competing loyalties).

The potential for conflict of interest can exist whether or not an individual believes that the relationship affects his or scientific judgment.

Financial relationships (such as employment, consultancies, stock ownership, honoraria, paid expenses and testimony) are the most easily identifiable conflicts of interest and those most likely to undermine the credibility of the journal, authors, and science itself...' [4]

Criteria for Acceptance of Manuscript

The APJHM invites the submission of research and conceptual manuscripts that are consistent with the mission of the APJHM and that facilitate communication and discussion of topical issues among practicing managers, academics and policy makers.

Of particular interest are research and review papers that are rigorous in design, and provide new data to contribute to the health manager's understanding of an issue or management problem. Practice papers that aim to enhance the conceptual and/or coalface skills of managers will also be preferred.

Only original contributions are accepted (ie the manuscript has not been simultaneously submitted or accepted for publication by another peer reviewed journal – including an E-journal).

Decisions on publishing or otherwise rest with the Editor following the APJHM peer review process. The Editor is supported by an Editorial Advisory Board and an Editorial Committee.

Peer Review Process

All submitted research articles and notes, review articles, viewpoints and analysis of management practice articles go through the standard APJHM peer review process.

The process involves:

1. Manuscript received and read by Editor APJHM;

2. Editor with the assistance of the Editorial Committee assigns at least two reviewers. All submitted articles are blind reviewed (ie the review process is independent). Reviewers are requested by the Editor to provide quick, specific and constructive feedback that identifies strengths and weaknesses of the article;

3. Upon receipt of reports from the reviewers, the Editor provides feedback to the author(s) indicating the reviewers' recommendations as to whether it should be published in the Journal and any suggested changes to improve its quality.

For further information about the peer review process see Guidelines for Reviewers available from the ACHSM website at www.achse.org.au.

Submission Process

All contributions should include a covering letter (see above for details) addressed to the Editor APJHM and be submitted either:

(Preferred approach)

1) Email soft copy (Microsoft word compatible) to journal@achse.org.au

   Or

2) in hard copy with an electronic version (Microsoft Word compatible) enclosed and addressed to: The Editor, ACHSM APJHM, PO Box 341, North Ryde NSW 1670;

All submitted manuscripts are acknowledged by email.

NB

All contributors are requested to comply with the above guidelines. Manuscripts that do not meet the APJHM guidelines for manuscript preparation (eg word limit, structure of abstract and main body of the article) and require extensive editorial work will be returned for modification.

References

1. Hayles, J. Citing references: medicine and dentistry, 2003;3-4. Available: <http://www.library.qmul.ac.uk/leaflets/june/citmed.doc> (Accessed 28/02/06)

2. Doherty M, Smith R. The case for structuring the discussion of scientific papers. BMJ. 1999;318:1224-1225.

3. Perneger TV, Hudelson PM. Writing a research article: advice to beginners. Int Journal for Quality in Health Care. 2004;191-192. Available: <http://intqhc.oxfordjournals.org/cgi/content/full/16/3/191> (Accessed 1/03/06)

4. International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. ICMJE. 2006. Available: <http://www.icmje.org/> (Accessed 28/02/06).

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Health Administration Press. Journal of Health care Management submission guidelines. Available: <http://www.ache.org/pubs/submisjo.cfm> (Accessed 28/02/06)

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The Medical Journal of Australia. Advice to authors submitting manuscripts. Available: <http://www.mja.com.au/public/information.instruc.html> (Accessed 28/02/06)

Further information about the Asia Pacific Journal of Health Management can be accessed at: www.achse.org.au.

About the Australasian College of Health Service Management

ACHSM (formerly Australian College of Health Service Executives) was established in 1945 to represent the interests of health service managers and to develop their expertise and professionalism. Today, the college is the leadership and learning network for health professionals in management across the full range of health and aged care service delivery systems in Australia and New Zealand and the Asia Pacific with some 3,000 members from both public and private sector organisations and non-government and not-for-profit organisations.

ACHSM aims to develop and foster excellence in health service management through the promotion of networking, the publication of research, and through its educational and ongoing professional development activities, including accreditation of tertiary programs in health service management, mentoring and learning sets.

ACHSM has Branches in all Australian States and Territories, New Zealand and Hong Kong. Memoranda of Understanding link ACHSM with other health management bodies in the Asia Pacific. As an international organisation, ACHSM is able to draw upon the experiences of researchers and managers in Australia, New Zealand, Hong Kong and other countries within the region to give readers valuable insights into management issues and approaches in a range of cultures and jurisdictions.