University of KwaZulu-Natal

Training needs of Medical Managers in public hospitals in KwaZulu-Natal

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DECLARATION

I ……declare that

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I would like to thank my whole family for their tremendous support throughout this very challenging, but rewarding experience. Their prayers and words of encouragement saw me through all the times when I was feeling most challenged.

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Last but not least, I would like to thank my supervisor Mr. Alec Bozas for his amazing patience and calm approach as a supervisor. I couldn't have asked for a better supervisor under the circumstances.

Dedication

I dedicate this work to my late father Harry Benson Busani Ngidi, my mother Abigail Bongekile Ngidi, my son Khwezi, my Partner Xolani and my niece Lungisile. Through Him all things are possible.

Abstract

National healthcare departments all over the world are facing the problem of rationing very limited resource to achieve acceptable levels of health care for their citizens. At the centre of healthcare challenges is the problem of an increasing disease burden, increasing pharmaceutical prices, increasing healthcare worker remuneration and the globalisation of healthcare services. Under such restrictive and competitive conditions, healthcare organisations need to find more efficient ways of working. This puts healthcare managers at the forefront of efforts to improve healthcare services and to find new ways to do more with shrinking resources. The need for well-trained managers is at its most critical level, especially in Third World countries like South Africa. This study set out to establish whether training needs existed amongst Medical Managers in public hospitals in the Province of KwaZulu-Natal, South Africa. Should training needs be found to exist, the aim was to establish where those needs may be. The study then identified what Medical Managers perceived as the preferred training methods for delivering the necessary training. The study had a sample size of 30 respondents out of the 54 potential respondents. This represents a response rate of 55.5 percent. The research method that was chosen for the study combined both the quantitative and qualitative methods through a questionnaire that listed 37 tasks. Each Medical Manager had to rate these tasks on their relevance, their own perceived performance of the task, the likelihood of receiving any required training through a formal training method like courses for each task and finally the likelihood of receiving training through on the job training for each task. The questionnaire also included an open-ended question that asked respondents to list up to ten additional training needs which had not been covered by the questionnaire. The study found that all the tasks which were audited were relevant, that the perceived level of overall performance was high and there was an almost equal preference for both formal and informal training method. Based on this study's findings, training initiatives targeting this group of managers should ideally combine both formal and informal training methods. A recommendation for further research with a more qualitative approach is being made to better understand the context within which the training needs exist. The minimisation of subjectivity of ratings through the involvement of Medical Manager Supervisors might also reveal a more objective overall outcome to the analysis of the problem.

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CHAPTER ONE

INTRODUCTION TO THE RESEARCH

1.1 INTRODUCTION

This chapter will put forward the problem to be researched and present a brief background to the study. The objectives are highlighted and the key research questions. The limitations and the significance of the study and the research methodology adopted are elaborated on. An outline of what is covered in all the chapters is also presented.

In the 2011 State of Nation address the South African President, Mr. Jacob Zuma, highlighted the country's healthcare priorities when he said "In the health sector, this year we will emphasise the appointment of appropriate and qualified personnel to the right positions". He also said, "We need qualified heads of departments, financial officers, district health officers and clinic managers" (President of the Republic of South Africa, 2011). At the core of any successful organisation one would expect to find appropriately trained managers. However, the President's statement on healthcare management clearly identified Management as one of the challenges within the South African National Department of Health.

This study sought to establish whether any training gaps exist in the management training of Medical Managers in public hospitals in KwaZulu-Natal. Appropriately trained managers are crucial to the success of any organisation. Public healthcare facilities are the key instruments for the successful delivery of a healthy nation. In turn, Medical Managers partially facilitate the production of a more productive workforce through increasing productivity by decreasing health-related absenteeism and by running effective health institutions. In a study done on healthcare management training needs in Pakistan, it was quoted that "Economic development of a country is very closely related to the health of its citizens" Schieber and Maeda, (1999) in (Khurshid, 2010). Managers are at the forefront of public healthcare management and are therefore a key resource. Ensuring that Medical Managers are adequately empowered to deliver on their mandate to effectively and efficiently manage healthcare resources, is a strategic intervention which was highlighted in the South African National Department of Health's Strategic Plan (Department of Health, 2011c).

1.2 BACKGROUND TO PROBLEM

The problem of training gaps amongst Medical Managers is not a problem which is confined to the province of KwaZulu-Natal. The problem has been identified as a national concern. This was reflected by the South African National Department of Health's response to the Millennium Development Goals report of poor performance in certain areas of the health-related Millennium Development Goals by the Southern African region. In 1999 the United Nations member states put together a list of eight goals for each member state to achieve by the year 2015. These goals were meant to help lift citizens of these countries out of poverty and empower them to be economically active members in their countries, "Nine years ago, world leaders set far-sighted goals to free a major portion of humanity from the shackles of extreme poverty, hunger, illiteracy and disease" (United Nations, 2009) the Millennium Development Goals (MDG) are:

- Goal 1: Eradicate extreme poverty and hunger
- Goal 2: Achieve universal primary education
- Goal 3: Promote gender equality and empower women
- Goal 4: Reduce child mortality
- Goal 5: Improve maternal health
- Goal 6: Combat HIV, AIDS, malaria, and other major diseases
- Goal 7: Ensure environmental sustainability
- Goal 8: Develop a global partnership for development

Although the goals overlap between different South African government sector service delivery mandates, Millennium Development Goals (MDG) 4, 5 and 6 are primarily health-related and therefore have been at the core of all service delivery efforts within the South African healthcare sector. In the National Department of Health (NDoH) 2011 Annual Report, the South African Minister of Health, Dr. Aaron Motsoaledi stated:

> "In 2010, the government revised its medium-term strategic framework (MTSF) for 2009-2014, and adopted a set of 12 key outcomes aimed at enhancing the pace of service delivery and accountability. The department is responsible for Outcome 2, which is: 'A long and healthy life for all South Africans.'

The health sector's NSDA (Negotiated Service Delivery Agreement) 2010-2014 is an implementation plan for Outcome 2. To realise Outcome 2, the health sector must achieve four outputs:

Output 1: increasing life expectancy;

Output 2: decreasing maternal and child mortality rates;

Output 3: combating HIV and AIDS and TB; and

Output 4: strengthening health systems' effectiveness.

These outputs are consistent with the health-related Millennium Development Goals (MDGs) that the nations of the world need to achieve by 2015" (Department of Health, 2011b). Each year since 1999, the progress of each United Nations member state and different regions of the world have been monitored and with each report, countries have had to re-adjust their strategies to maintain positive progress keep and on target. Within the South African context, there has been some progress on the health-related MDGs although this has often been far from sufficient. As part of the Sub-Saharan Region, South Africa has shown very slow progress in the achievement of the health related MDGs (2011). There have been setbacks, some of which were beyond the country's control such as the economic downturn of 2009 which was a global phenomenon.

1.3 PROBLEM STATEMENT

South Africa has had various challenges in achieving optimal health for all its citizens. The country is plagued by wide spread of diseases like Tuberculosis (TB) and Human Immuno-deficiency Virus (HIV). As one of the contributors to this problem, is the problem of inadequately resourced public healthcare facilities. In his research titled "The Skills Gap in Hospital Management: A Comparative Analysis of Hospital Managers in the Public and Private Sectors in South Africa" (Pillay, 2010) stated that "One of the key constraints to achieving optimal health outcomes in South Africa, and indeed in most of the developing world, has been the lack of health management capacity". He further stated that, "Appropriate programmes based on the needs and experiences of managers can then be put in place to train managers to provide

leadership and to ensure a sustainable improvement in the quality of care and health of the communities their organisations serve." In 2009 when the South African National Department of Health (SANDoH) put together strategies to improve public healthcare outcomes, the training of managers was a priority and it remains the case to date. In the SANDoH Strategic Ten Point Plan which guides this healthcare sector's priorities until 2014, the training of institutional managers remains at the top of the priorities (Department of Health, 2011c).

In a study was conducted by Bax, Berkenbosch and Busari, (2011) on Dutch medical specialists who are in roles similar to that of the Medical Manager. This study was called, "How do medical specialists perceive their competency as physician-managers?" and that data was gathered from 127 specialists who were given questionnaires. The conclusion was that most of the specialists/Medical Managers expressed the need for training in management. Further to this, clinicians who pursue a management career often need additional formal management qualifications. For an example the results of a study titled "Management and medical leadership-evaluation of training needs and pathways" (Wadoo, Shah, Sajjad and Fearnley, 2010), agreed with this view. Countries all over the world, but most significantly in Third World countries, find themselves having to ration extremely limited resources in public health institutions. This is exacerbated by the increasing burden of disease, escalating pharmaceutical prices, escalating clinician remuneration and the globalisation of healthcare with the added brain drain challenges. Ill-equipped managers will therefore add an extra burden to already strained institutions, rendering those institutions even more inefficient and ineffective.

This study therefore aimed to establish whether Medical Managers at public hospitals in KwaZulu-Natal face a similar problem in terms of a gap in management training. Should it be proven to be true, the study will further seek to establish where the training needs are and how best to provide training to remedy the situation as perceived by the Medical Manager respondents.

1.4 OBJECTIVES

The study aimed to achieve the following objectives:

- To establish whether any management training needs exist amongst Medical Managers in public hospitals of KwaZulu-Natal;
- To determine where the training gaps are
- To establish the training method most preferred by Medical Managers to address training needs identified between :
    - formal training through courses and workshops or
    - informal training through experiential learning through on-the job training.

1.5 KEY RESEARCH QUESTIONS

The assumption is that there are training gaps in the management training of Medical Managers based on wide views internationally that clinician managers, although often excellent in their clinical management skills, often lack the fine general management skills needed to manage clinicians and other health resources effectively and efficiently. Amongst many supporting this view is Williams (1997) in an article in the British Medical Journal where it was stated that "Doctors should become managers. However, just as professional managers often lack the necessary insight into the clinical aspects of patient care, doctors without suitable training lack the insight into the more corporate function of a manager"(Williams, 1997: 817). The National Department of Health's prioritisation of the training of managers in hospitals in its ten point plan also supports this view. The research questions will therefore be as follows:

- Are there management training needs amongst Medical Managers in public hospitals of KwaZulu-Natal?
- Where are the gaps in the training of these Medical Managers?
- How best can the training gaps identified be addressed, taking into account the formal and informal teaching methodology preference amongst respondents?

1.6 LIMITATIONS

As highlighted in the South African National Department of Health's Strategic Ten Point Plan, the problem of training is a national priority. Due to the limitations of private funding, this study was confined to the province of KwaZulu-Natal. A better resourced study could extend this study to all Medical Managers in all public hospitals of South Africa which means that at the end of the research, recommendations could be made at a national level. The MDG (Millennium Development Goals) progress report is a reflection of the country's progress as whole, not individual South African provinces, so national results of such a study would be more appropriate.

1.7 SIGNIFICANCE OF THE STUDY

This study is important because it contribute towards addressing a priority area of the South African National Department of Health's Ten Point Plan, namely training hospital managers to improve the operational management of health facilities. This research focuses on a specific line of managers within this group i.e. Medical Managers. The research will make a relevant contribution towards possibly implementing relevant and much needed training for this group of managers. The overall morale, confidence and effectiveness of these managers will be improved, and this will both directly and indirectly contribute to improved health outcomes and will result in a healthier and more productive society in the province of KwaZulu-Natal.

1.8 RESEARCH METHODOLOGY

The research data was collected via a questionnaire using the Hennessy-Hicks Training needs analysis manual and questionnaire from Birmingham University. The Hennessy-Hicks manual has been widely used to assess the training needs of health care employees all over the world. The original questionnaire was presented in a manual format by its authors, and steps for the adaptation of questionnaire to individual settings, was clearly highlighted. To confirm the validity of the additional tasks added to adapt the questionnaire, the adaptation was done in

consultation with a small focus group of healthcare Managers within e-Thekwini Metropolitan hospitals. Although the manual has been made available for public use through the World Health Organisation, official permission was also granted by one of the authors of the manual, (Appendix 1).

The fully adapted and validated questionnaire will be sent to Medical Managers of all KwaZulu-Natal hospitals via e-mail. Based on the total number of Public hospitals in the province of KwaZulu-Natal the estimated number of respondents is seventy-one. Data analysis was done manually.

1.9 CHAPTER OUTLINE

- Chapter One : Research Proposal

  The research concerns the training needs of Medical Managers in public hospitals in KwaZulu-Natal. A brief background to the problem is introduced that brings into perspective the motivation for the study. The study's problem statement, research questions, objectives, research methodology, significance and limitations are discussed

- Chapter Two : Literature Review

  The literature review examines the role of Medical Managers and their training gaps. The recommended training methodology is reviewed from international sources on the subject.

- Chapter Three : Research Methodology

  The research method adopted for the study is highlighted and the motivation behind the selection is given. Respondents and their location, the research approach, sampling technique, data collection method, ethical issues, and the research tool are discussed. A brief overview of how the field work and data analysis was done is also discussed.

- Chapter Four : Data Analysis
  Data collected is presented and discussed.

- Chapter Five : Conclusion and Recommendations
  Based on both the literature review and this study's findings, a discussion of each of the objectives appears under conclusion and recommendations. The training methodology of choice based on the findings of this research is discussed and suggestions for further research are made.

1.10 SUMMARY

It seems that the challenges of healthcare management training amongst clinicians at all levels are well recognized as being problematic. The challenge is the plans that countries are going to put in place to change the current circumstances. The problem is possibly much bigger than this study but this study intends to contribute towards a much greater effort by the South African Government to train hospital managers. This is one of its initiatives towards improving health outcomes and therefore improving the lives of the citizens of South Africa. Chapter two contains a review of literature that is relevant to the issues being researched.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter looks at the available literature concerning medical management training needs. There are five sections within the literature review, each one aligned with the objectives of the study. The literature review will be approached as follows:

- The Background/Introduction to medical management;
- The Role of the Medical Manager. (What Medical Managers do?);
- Literature identifying key competency areas and gaps in the training of Medical Managers and
- Literature proposing how these gaps should be filled i.e. recommendations on teaching methodology for training Medical Managers.

2.2 BACKGROUND

Pathogenesis is a medical term used to define a process by which a pathology or disease process comes into being. This chapter will seek to establish the processes that have contributed to the perceived training gaps in the training of clinicians as managers, in this case Medical Managers. The training gap, in this instance, is the pathology. The chapter will also look at proposed solutions. The gap was highlighted two decades ago when it was stated that, “Managed care is providing opportunities for physicians interested in new and different types of work” O'Connor (1993). Testimony to this statement is the widespread movement of physicians into formal management positions as a planned career choice. The steady rise in the membership of the American College of Physician Executives is a reflection of the growth of medical management as a speciality in the United States (O'Connor, 1993).

Referring to physician management implications within health care organisations, O'Connor (1993) stated that healthcare organisations need to adapt to the many new demands in modern healthcare. It is no longer commonplace that resources are plentiful and diseases few. In modern healthcare, physicians have to do with fewer resources to accomplish similar or better health outcomes. This means that health organisations need to move from "an expansionist mentality" to a "restrictionist" mentality. O'Connor noted that this has serious implications for physicians who now have to make more decisions with smaller amounts of information. This is due to the limitations on how many tests and procedures can be carried out as a result of strict healthcare cost containment initiatives. O'Connor further stresses that in such an environment, effective management is essential.

There has been a body of research within the last few decades into the role of and the challenges faced by individuals who are appointed to the position of Medical Manager. At the centre of this literature lie two very significant dynamics that naturally materialise due to the hybrid nature of the role played by Medical Managers as both physicians and managers. They need to have the ability to juggle the contradicting responsibilities between their two professional worlds, each with its own culture.

Tension often brews between physicians and the authorities that try to manage them. The first source of tension is that the Medical Manager is often seen as "one of them" (i.e. healthcare managers) by their fellow physicians. The following quotation sums up the situation:

> "Imposed upon the profession by the state, but operating from within it, clinical directors (referring in this case to Medical Managers) embody the tension between the managerial and professional structures and cultures and the struggle for power and control in the NHS in the UK" (Thorne, 2002: 14).

In their work titled "Doctors and managers: a problem without a solution" Edwards *et al* ., (2003) explain the source of doctor-manager tensions. Referring to research done previously on this topic, they suggest that the difference in the culturisation of managers as administrators and doctors as clinicians, has had a significant contribution towards existing tensions between these groups of professionals. This implies that the cultures conflict at various points of patient care.

On the one hand managers are organisation-orientated and accountable to the whole population, so they focus on the efficient allocation of resources. On the other hand, physicians are individual patient-orientated, focusing on the immediate needs of an individual patient and wanting to use all available resource to heal the individual patient.

The professional autonomy afforded to the clinical practice of doctors, makes it very difficult for managers to influence doctors' practices. This has been identified as another source of tension. History has also awarded a lot of status and control to doctors within their profession. Under modern healthcare management, doctors find themselves very reluctantly having to relinquish much of their power (Edwards *et al* ., 2003). Kippist (2009) concurred with this view with specific reference to the Australian healthcare system, "New public management now underlies health care management thinking, objectives and practices" (*Ibid*: 643). New public management systems underpin the current state of healthcare and challenge the values on which individual physician clinical practice is based. This best summarised as "the business of health" versus the physicians' view of "the value of care and cure" Kippist (2009). These conflicting priorities are a constant source of tension between the two groups of professionals. The Medical Manager is caught at the centre of this conflict.

Adding to the complexity of the Medical Manager's work of managing physicians is the tensions between physicians themselves and between physicians and other healthcare workers. Physicians are notorious for misbehaving at work (Goettler *et al* ., 2011). Further stating that, "Our data support the finding that high intensity areas have a higher likelihood of disruptive behaviour" (*Ibid:* 1603*)*. This implies that the working environment in healthcare organisations are high intensity areas with a higher likelihood of physicians misbehaving at work due to the inherent stress levels of their profession. Dealing with life and death decisions under very restrictive conditions places physicians under a great deal of stress. This poses an additional management challenge for the Medical Manager who is responsible for managing physicians as both clinicians and as employees.

The second source of tensions exists as a result of the relationship between the Medical Manager and the non-Medical Manager colleagues i.e. the Chief Executive as supervisor and other

executives within the working environment. The Medical Manager's credibility within the management team depends on his/her abilities to deliver the required results through his/her management and leadership of the medical professions in alignment with the self-preserving goals of healthcare facilities that concentrate on having to do more and more with shrinking resources.

To understand the nature of the training requirements of Medical Managers, one needs to understand the background in which Medical Managers are trained and cultured into their roles as physicians and, subsequently as Medical Managers. One also needs to understand the nature of the environment in which they work. For this reason the review of literature will explore the existence of management training in the medical training of Medical Managers from undergraduate level up to the various levels where physicians are appointed to the position of Medical Manager. The review also looks at literature describing the work routines i.e. what Medical Managers actually do. Merging these two aspects of the Medical Manager's training and job expectations is likely to give one a clearer picture of whether training needs exist and where the training gaps might be if they are at all present. Finally, literature looking at the recommendations of various approaches to addressing the training needs of Medical Managers is reviewed.

It is important to note that with certain changes depending on where you are in the world, the job of Medical Manager is, generally speaking, an individual with first and foremost a medical degree who then either with or without additional management training and or clinical experience, is appointed the role of Medical Manager. This individual then becomes the manager of clinical services. The job includes managing physicians and allied healthcare workers such as therapists (physiotherapist, speech therapists and so forth), dieticians, radiographers, dentists and others. Supporting this broad definition Dwyer stated that,

> "The specialty of Medical Management has developed in various forms across differing continents, all with the same fundamental principles of combining medical knowledge and expertise with business and healthcare management training" (Dwyer, 2010: 514).

In Australia for example, the definition of a Medical Manager is,

> "A specialist Medical Manager is a registered Medical Practitioner with a medical degree and dual qualification in medicine and management, who has taken a predominant management role in healthcare" (Dwyer, 2010: 515).

In the case of Australia, a medical management has been developed into a specialty within medicine, and those in the position need specific additional training and certain clinical experience. During the literature review various different titles were discovered which referred to the same or similar positions as Medical Manager in South Africa were:

- Medical Manager (mostly in Australian Literature);
- Physician Executive (United States Literature);
- Clinical Director (United Kingdom);
- Health Administrator;
- Physician Manager and
- Clinical Manager.

Interestingly, a combination of all the titles is an accurate reflection of the duality of the role of the individual holding the position of Medical Manager, who fulfils the role of both manager and a physician. Although these terms were therefore used interchangeably, they did not always refer to the same organisational position. For the purposes of this research, this is acceptable because the intention of the literature review was to understand the management training levels of doctors at various levels of their post graduate clinical practice, whose core duties were spread between clinical practice and management to one extent or another. Management training was examined as far back as undergraduate level because management training at any of these levels has been assumed to impact on the clinician's knowledge base and therefore their readiness to take on a management role later on in their careers.

Because "approximately 65 medical schools in the United States offer a business degree in combination with a medical degree" (Lazarus, 2012: 291), some physician managers come straight out of medical school, with barely any clinical experience, straight into business school and from there into management positions. It is therefore of interest to understand how much

management training there is in the medical training curricula both in the under graduate and post graduate levels building up to taking up the position of Medical Managers.

It is also worth noting that in some countries, the concept of management development in early career doctors is already an accepted standard and norm as stated in the United Kingdom context. Referring to management and leadership development amongst junior doctors, (Coltart *et al* ., 2012: 1848) said,

> "One solution might be to uncouple leadership and clinical development, and provide early career doctors with the opportunity to gain management and leadership experience earlier in their career"**.**

Such insight is important to help understand the background from which Medical Managers are developing internationally. Within the province of KwaZulu-Natal, to be appointed to the position of Medical Manager, one has to have a basic qualification in medicine and as few as three years' experience as medical practitioner. These are the minimum qualifications and experience as recently as November 2012 (Appendix 2).

2.3 THE ROLE OF MEDICAL MANAGERS: THE LITERATURE

Amongst other responsibilities, the Medical Manager must effectively manage a group of what is generally perceived as the most difficult employees in healthcare organisations to manage, namely doctors. Due to the nature of their work and the amount of professional autonomy given to doctors by their professional bodies, managing their day to day operations becomes a science in its own right. Figure 2.1 shows the position of the Medical Manager within a healthcare organisation and their focus of influence and responsibility. They have the responsibility of managing a highly professionalised group of health care workers and balance the needs and interests of such professionals with those of the patients and the management team (referred to as the strategic apex in Figure 2.1).

According to (Hoff, 1998: 483),

> "Physician executives can arguably offer something no other stakeholder can, namely, the perspective of both clinician and manager, in addressing issues in the medical workplace that currently generate conflict between different entities" (Hoff, 1998). In another study by (Succi and Lee, 1998) found that, "Hospital managers are now rewarded for conserving resources and containing costs, while physicians continue to gain respect for utilising all possible resources to provide high quality care." (*Ibid*: 399). This highlights what the average Medical Manager's responsibilities are in his/her roles as part of the hospital's executive teams in hospitals and also highlights the challenges that they face in their position.

These developments in healthcare responsible in part, for the emergence of the Medical Manager position or role with the purpose of neutralising these tensions, sometimes with unfortunate consequences. While previous healthcare reforms sought to develop a gap between doctors and managers, recent reforms have attempted to reduce that potential conflict. Unfortunately, the previously externally focused structural conflict seems to have been taken on by clinical directors (Mo, 2008). Meaning that, the Medical Manager as the manager caught in the middle of the two professions, absorbs a lot of the stress of the tensions.

Figure 2.1 illustrates Mintzberg's 5 Parts within a healthcare organisation, highlights the exact position of a Medical Manager within the healthcare organisation and illustrates their responsibilities.

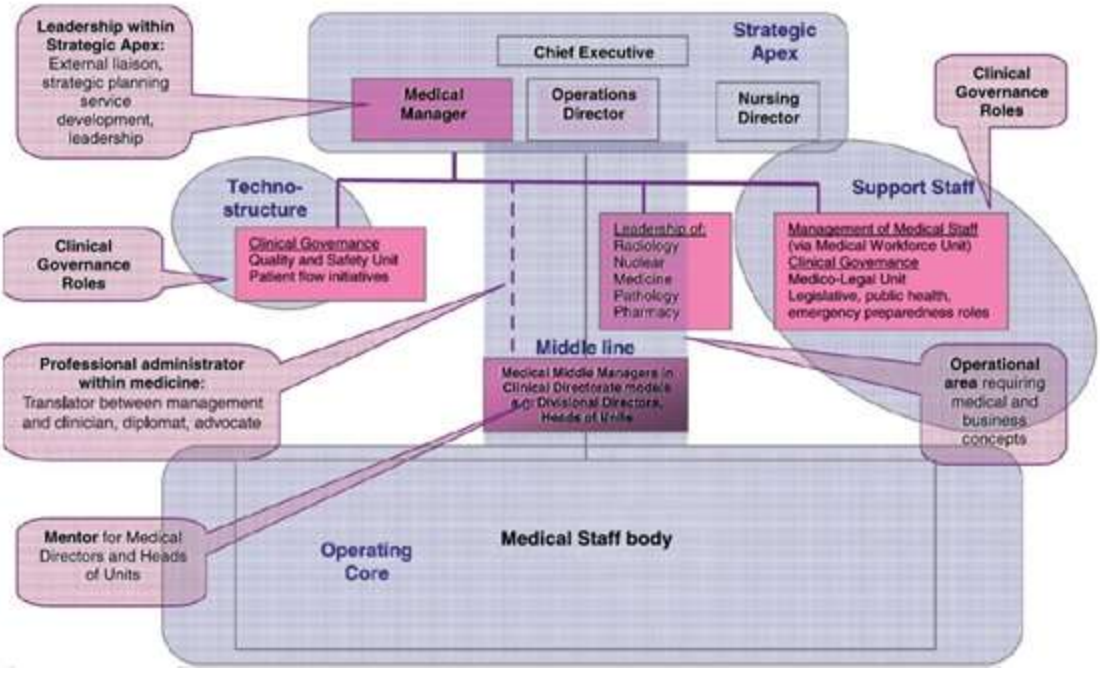

Figure 2.1 Mintzberg's 5 Parts within a Healthcare Organisation and the Roles of Medical Managers. (Source: DWYER, A. J. 2010: 517.) Medical Managers in contemporary healthcare organisations: a consideration of the literature. *Australian Health Review,* 34**,** 517.

Medical Managers' duties include overseeing issues of clinical governance, management of medical staff, acting as professional administrator, the mentorship of senior doctors and many other roles. This is in line with the responsibilities highlighted in the KwaZulu-Natal Department of Health Medical Manager position advertisement (Appendix 2).

Table 2.1 which shows Mintzberg's Healthcare Organisational Structure Theory elaborates further on the dynamics at play within healthcare organisations. This structure has serious and challenging implications for the medical management role. The Medical Manager guides and oversees medical operations but they have no direct authority over the individuals that work within the clinical units. Those units have their own clinical heads, sometimes referred to as clinical managers or heads of clinical departments or units. The clinical heads, over whom the Medical Manager has direct authority, exercise more authority over those medical professionals within their individual units.

The distribution of authority and power, due to the autonomous nature of the medical profession, has been decentralised from the strategic apex and internalised within the medical professions i.e. clinical units (Mo, 2008). This further supports the view that the management of physicians often proves a very difficult undertaking due to the fact that the manager is held responsible for the actions of workers they don't really control; at best managers can only influence these physicians, including the clinical heads of clinical units. Table 2.1, on Mintzberg's healthcare Organisation Theory summarises these dynamics.

Table 2.1 Mintzberg's Healthcare Organisation Structure Theory

(DWYER, 2010) Medical Managers in contemporary healthcare organisations: a consideration of the literature. *Australian Health Review,* 34**,** 517.

Table provides summarised features and description of Mintzberg's research

Fundamental principles of Mintzberg's structure theory	Main features	Description
There are 5 parts in any healthcare organisation	Operating core	Core workers undertaking the processes of the organisation e.g. doctors, nurses
	Middle line	Middle managers in operational core, e.g. heads of units, operations managers, nurse unit managers
	Strategic apex	CEO, executive managers
	Support staff	Human resources, information systems
	Techno-structure	Analysts who serve the organisation by affecting the work of others. They are removed from the operating work flow, but they design it, plan it, change it or train the people who do it. Includes quality improvement managers, patient access coordinators.
Medical staff in healthcare organisations form a Professional Bureaucracy	A locus of control with the professions	Physicians essentially make the predominance of the decisions that affect the core business of the organisation – patient care. They make decisions to admit patients, what test to be ordered, what treatment to be given, and when the patient can be discharged; they have the power of expertise
	Relying for coordination on the standardisation of skills and its associated design parameter: Training and indoctrination	It hires duly trained and indoctrinated specialists or professionals for the operating core, and then gives them considerable control over their own work
	Decentralised decision making processes	As each patient is unique and the management often complex, the decision-making processes are therefore decentralised to the professions.

According to Mintzberg's Healthcare Organisation Structure Theory there are five parts to any healthcare organisation. The Medical Manager is part of the strategic apex in the role of executive manager as already mentioned. The strategic apex consists of the Chief Executive Officer, Medical Manager and other executive managers. The other four parts are the operating core, the middle line, support staff and techno-structure.

Mintzberg's Healthcare Organisation Structure Theory goes to the centre of the structure of public health organisations in KwaZulu-Natal. A closer look at Figure 2.1 reveals that the Medical Manager seems to have very limited direct influence over what physicians actually do on a day to day as each operational unit has its own clinical head. The Medical Manager would usually only try to persuade or influence heads of clinical units to follow a particular disease treatment protocol or buy-in into any organisational strategy using evidence based research findings and their own experience as a physicians and as managers. This significant lack of influence is due to the medical profession's bureaucracy which is also mentioned in Mintzberg's Healthcare Organisation Structure Theory.

It becomes clear that the type of management approach in this instance will rely heavily on both negotiation and on high levels of influence within the medical profession, especially influence over the heads of clinical units. The medical profession is known for its heavy reliance on evidence based practices. The Medical Manager needs to be able to influence physicians to change their practices or adopt organisational objectives as their own, even at times when those objectives might be in conflict with patient interests for which the physician is supposed to advocate. A Medical Manager needs to be familiar with the latest research and proven clinical evidence. He/she also needs to be a persuasive manager and respected leader with influence. Illustrating the conflicting objectives between Medical Managers and doctors it was stated that "Sound business decisions can be in conflict with good medical decisions and sound medical decisions can be in conflict with good business decisions. Which way to go?" (Natale and Sora, 2009). It is clear that managing physicians requires a great amount of influence and skill, making the role of the Medical Manager a complex one.

The role of Medical Manager is further described by (O'Connor, 1993: 572) that, "Physician participation is crucial to the hospital's survival. Because physicians control more than 80 percent of the decisions affecting health costs, they drive virtually every aspect of care from admission to discharge". These decisions range from what medical investigations to order for the diagnosis process, what treatment to prescribe, what diet the patient is to be given and so forth. Proposing that since the core of the business of health is made up of activities based on the decisions of physicians, physicians are therefore at the core of healthcare cost determination.

O'Connor also puts forward that no other worker group within healthcare organisations has more influence on healthcare costs than physicians, "Hospital administrators are becoming more active in the supervision of clinical operations. Motivated by the need for efficiency, managers evaluate physician practice patterns in order to ensure maximum productivity" (*Ibid*: 573).

In relation to the culture that exists amongst doctors, (Thorne, 2002: 16) stated that, "Collegial structures, limit hierarchy and accountability....create a form of double closure that contrasts starkly with the hierarchical, accountable structures of management". According to (Thorne, 2002: 17**)** also stated that, "Any attempts by general managers to constrain and control doctors resulted in doctors resisting, ignoring or defeating them which inhibited change and increased spending". Pivotal to the role of the Medical Manager is the ability to manage this key group of medical professionals. With such a challenging group of professionals to manage, adequate skilling and empowerment of the Medical Manager is at the centre of the survival of health care organisations. One can conclude that such training would have to be precise and planned and cannot be left to chance. Supporting the view of the pivotal role of physicians in health care management it was said, "Changes in the structure of health services have focused attention on physician clinical practice as a way of both reducing health costs and simultaneously raising the level of health care," (Mano-Negrin and Mittman, 2001: 264).

One can deduce that managers, who manage and influence the clinical practices of doctors in a way, significantly control the final outcomes in healthcare facilities both clinically and economically. One may then argue that for Medical Managers, a thorough understanding of the needs of physicians would be a good place to start in the process of focusing on winning the loyalty and buy-in of physicians. Insight into what physicians want within healthcare organisations influences what Medical Managers are expected to do. LeTourneau (2004) highlighted that what physicians wanted amongst other things was to be understood, to representation (i.e. physician advocacy) and to have a stable working environment (Appendix 3). LeTourneau further stated that physicians wanted clearly articulated organisational strategic plans and solid communication from leadership.

Looking at these expectations it is easy to ascertain how the physicians' needs might be in conflict with those of healthcare management. The focus of physicians is on the needs of the patient while the expectations of the organisation's management are not a priority to them (LeTourneau, 2004). This point of view is in line with many other views already mentioned. The role of Medical Manager as an advocate of physicians' interests is one which is held by physicians. They expect the Medical Manager to act according to their needs.

Elaborating on another aspect of what Medical Managers do another study found that,

> 'On average, physician executives practiced medicine approximately one full day per week (i.e. 20 percent). However half of all physician executives responding indicated that they did no direct patient care. In fact, only 15 percent said they saw patients for at least three days per week' (Hoff, 1998: 489).

In Australia Medical Managers actually do not perform any direct patient care as highlighted by Dwyer (2010). This means that in their dual role as manager and clinician, Medical Managers work as managers or administrators for the major part of their day. In another study in relation to time limit on management duties for Medical Managers it was stated that,

> "Initially the hospital had intended the new department managers to stop working clinically, but after negotiations and strong pressure from the physicians, 20 per cent clinical work was accepted. In practice, the amount of clinical work varied from none to 1-2 days per week" (Mo, 2008: 406).

To an extent, it seems that maintaining a limited amount of clinical practice seems to be an agenda pushed by the Medical Managers themselves, possibly in an effort to stay up to date with current clinical practices and maintain a level of acceptance amongst their clinician colleagues. This confirms that around 80 percent of most Medical Managers' time is spent on management duties. This has significant implications for the training and required skill competencies for doctors who engage in such levels of management in these healthcare organisations. However, this highlights the fact that apart from their management duties, Medical Managers are still viewed as clinicians and therefore still do some clinical work over and above their management

duties. As is the case in Australia, South African Medical Managers do not do much clinical work as implied by the Medical Manager advertisement (Appendix 2).

Elaborating on the exact tasks that Medical Managers are expected to perform, Betson and Pedroja (1989) in their work titled "Physician managers: a description of their job in hospitals", e-mailed a task inventory to 893 members of the American Academy of Medical directors and received responses from 502 members. The findings as illustrated in Table 2.2 show that they found that Medical Managers' tasks revolved around the management of medical staff and their working environment, through policy and resource management. According to Betson and Pedroja (1989), policy management tasks were the most often performed category of tasks followed by programme management tasks. The least often performed category was resource management tasks which were generally unrelated to direct physician management such as infrastructure and wages.

Table 2.2 Management Tasks of Physician Managers by Category. BETSON, C. & PEDROJA, A. T. 1989. Physician managers: a description of their job in hospitals. Hospital & Health Services Administration, 34, 360.

Task	Most Percent	Task	Least Percent
Policy Management		Policy Management	
Attending medical staff committees	95.1	Deciding prices for services	26.4
Monitoring and reporting to administration issues of interest to medical staff	93.7	Lobbying regulatory agencies	24.2
Preparing policies or procedures	93.3	Chairing board committees	9.3
Communicating information to medical staff and governing body	92.1	Program Management	
Designing or reviewing new programs	90.1	Designing continuing education programs for nonphysicians	25.4
Monitoring and reporting to medical staff issues of interest to administration	89.8	Designing general educational programs	12.0
Attending administrative committees	87.8	Resource Management	
Preparing goals and objectives	85.6	Obtaining consulting services	27.2
Program Management		Supervising construction projects	20.3
Ensuring accreditation	88.4	Designing wage/benefit schedules for nonphysicians	13.0
Ensuring system for review and evaluation of medical staff competency exists	85.7	Designing contracts for nonphysicians	12.6
		Negotiating with unions	6.8

The percentages reflected in the table reflect the percentage of physicians who said they performed certain roles. The study then went into detail within the policy management category to ascertain which tasks are most often performed by Medical Managers within this category. It was revealed that attending staff committees, monitoring and reporting on issues of medical staff to managers, preparation of policies or procedures, communicating information to medical staff, designing or reviewing new programmes accounted for more than 90 percent of policy management tasks that Medical Managers performed.

According to Betson and Pedroja (1989) findings, Medical Managers are extensively involved in the planning, co-ordination and implementation of medical service. Medical Managers' tasks seem to revolve around understanding the needs and objectives of both the management and

medical teams and facilitating the synchronisation of the two to ultimately achieve the objectives of the healthcare organisation.

According to Betson and Pedroja (1989) analysis of tasks, Medical Managers are involved in all aspects of the clinical care planning, design and execution by physicians. The same is true to a lesser extent of the planning, design and execution of management objectives. This is because Medical Managers are more advisors on this platform as they work with manager colleagues of equal organisational status. Betson and Pedroja further analysed the programme management tasks that Medical Managers were engaged in (see Table 2.3).

Table 2.3 ***Policy Management Tasks for which More Than 75 Percent of Physician Managers Are Responsible in Hospitals. BETSON, C. & PEDROJA, A. T. 1989. Physician managers: a description of their job in hospitals. Hospital & Health Services Administration, 34, 361.***

Task	Percent of Physicians Responsible
Attend medical staff committees	95.1
Monitoring and reporting on issues of medical staff to administration	93.7
Preparing policies or procedures	93.3
Communicating information to medical staff and governing body of organization	92.1
Designing or reviewing new programs	90.1
Monitoring and reporting to medical staff issues of interest to administration	89.8
Attending administrative committees	87.8
Preparing goals and objectives for organization	85.6
Preparing agenda items for medical staff meetings	80.9
Ensuring standards of care are written and disseminated	76.8
Deciding on programs and medical services for organization	76.1

Betson and Pedroja (1989) found that Medical Managers were engaged in ensuring accreditation of services, ensuring medical staff competency, and designing programmes to ensure that health services are ethical, effective and meet professional standards (Table 2.4).

Table 2.4 Programme Management Tasks for which More Than 75 Percent of Physician Managers Are Responsible in Hospitals. BETSON, C. & PEDROJA, A. T. 1989. Physician managers: a description of their job in hospitals. Hospital & Health Services Administration, 34, 362.

Task	Percent of Physicians Responsible
Ensuring accreditation	88.4
Ensuring system for review and evaluation of medical staff competency exists	85.7
Ensuring system for review and evaluation of medical staff competency operates effectively	83.4
Designing programs to compare physicians' behavior to established standards of care in organization	82.8
Ensuring system for review and evaluation of credentials for new physicians exists	82.6
Ensuring data relevant to medical care issues are used appropriately	80.0

These findings further confirm that the management of physicians and their practices remains the most common task performed by most Medical Managers as reflected by this study.

The study further analysed the resource management tasks (Table 2.5) for which 75 percent or more of Medical Managers were responsible.

Table 2.5 Resource Management Tasks for which more than 75 of Physician Managers Are Responsible in Hospitals. BETSON, C. & PEDROJA, A. T. 1989. Physician managers: a description of their job in hospitals. Hospital & Health Services Administration, 34, 362.

Task	Percent of Physicians Responsible
Mediating conflict among physicians	84.3
Mediating conflict among physicians and nonphysician personnel	83.5
Mediating conflict among physicians and administration or governing body	78.4
Reviewing budget (or part)	75.2

In the management of physicians, Medical Managers managed matters of conflict resolution between physicians, as well as between physicians and other staff categories. In conclusion, Betson and Pedroja (1989) found that the task that Medical Managers were least responsible for were mostly those that dealt with the financial aspects of management.

Medical Managers were more involved with programme management tasks than with resource management tasks (Betson and Pedroja, 1989). The responsibility of Medical Managers does not seem to have changed over the years but because of the challenges associated with managing physicians and resource limitations, the focus has definitely shifted to finding ways and means of doing the same activities more effectively. Within the South African context, health reforms have seen the role of what was initially known as a Medical Superintendent (which was historically a medical doctor who had the responsibility to oversee both medical and management affairs within each public health institution). This role has been re-configured with the duties of the Medical Superintendent being split between a Chief Executive Officer (not necessarily medically trained) and Medical Manager (must be medically trained).

In a study done by Dwyer (2010), literature was reviewed on the evolving role of Medical Managers, highlighting the importance of recruiting and developing more physicians into the Medical Manager role. Table 2.6 on "The role of Medical Managers in contemporary healthcare

supported by literature", shows that the role of Medical Manager seems to have remained more or less the same in South Africa in contrast to the work done by Betson and Pedroja (1989) almost two decades ago.

The broad portfolio of the role of Medical Manager is to lead and manage medical staff, to be involved with the strategy development of the organisation as medical advisor to the executive, to be a champion for clinical governance and to be involved in clinical operational areas. These roles are similar to the roles defined by Betson more than two decades ago. In concluding his study, Dwyer said,

> "Medical Managers in healthcare organisations therefore have a theoretical basis and incorporate a portfolio of roles that are critical for both operational and strategic functioning of the organisation, as well as ensuring safe, high quality patient care,"(Dwyer, 2010: 521).

Table 2.6 Roles of a Medical Manager within Contemporary Healthcare Organisations supported by Literature. DWYER, A. J. 2010. Medical Managers in contemporary healthcare organisations: a consideration of the literature. Australian Health Review, 34, *520.*

Portfolio	Description
Leadership and management of medical staff	Leadership (professional administrator) of medical profession • Negotiator or mediator and diplomat within the medical profession • Translator or liaison between medical staff and management • Translator or liaison between the organisation and externally • Advocate for medical staff Medical Workforce Management • Appointments • Credentialing and Scope of Practice • Introduction of new technologies • Performance management • Ensuring ongoing competence through training and education • Medical workforce planning Mentoring and supervision of medical managers in Divisional Director or Head of Unit roles
Involvement with Strategy Development of the Organisation	Medical advisory role to the Executive In collaboration with CEO and Executive, strategic planning and service development
Executive Champion for Clinical Governance	Quality and Risk Management (adverse event monitoring, clinical and surgical audit, responding to patient complaints, medico-legal) Specific duties of the Chief Medical Officer • Legislative requirements (Designated Officer, Senior Medical Officer for compulsory testing) • Public health and emergency preparedness
Operational areas	Particular complex areas that benefit from clinical and management skills, such as Research, Diagnostic Services and Pharmacy Services, or acute and subacute services

In another study that set out to "present an empirically based conceptual study of the behavioural routines of hospital clinical managers based on multiple studies of clinical managers" Braithwaite (2004) highlighted major clinician management interests and concerns (Table 2.7).

The interests and concerns of Medical Managers mostly involved the management of medical staff, training and other human resource issues related to medical staff. Other resource management interests and concerns for example equipment, infrastructure, finance and customers were also highlighted. These were interests and concerns that were based on what the Medical Managers in Braithwaite's study did on a day to day to ensure an effective and efficient clinical or medical service.

Table 2.7 Behavioural Routines-Major Clinician-Management Interests and Concerns. BRAITHWAITE, J. 2004. An empirically-based model for clinician-managers' behavioural routines. Journal Of Health Organisation And Management, 18, 245.

Activity	Exemplar words and concepts	Approximate per cent of talk and behaviour involved
People	Staffing, motivating, assigning work, delegating, disciplining	26
Organisational/institutional	Buildings, beds, equipment, reports	14
Structure and hierarchy	Decentralising, departments, directorates, restructuring	12
Financial	Budgeting, revenue, accounting, resource management	10
Customer orientation	Complaints, compliments, customer queries and needs	8
Education and development	Training, teaching and learning, education	7
Achievement orientation	Objectives, goals, priorities, results, successes	6
Change	Inertia, rapid, new ways of working, resistance	4
Processes	Systems, processes, procedures	4
Decision making, problem resolution	Deciding, decisions, problem resolution, consensus	3
External relationships	Suppliers, external agencies, outside companies	3
Strategy and planning	Longer-term planning, strategic goals, plans	1
Data	Information, data, information technology	1
Quality	Continuous improvement, TQM, quality	1

According to this study's findings, the activities of Medical Managers revolve mostly around matters involving people, organisational/institutional structure and hierarchy, financial (budgeting, resource management) and customer relations. These are the areas into which Medical Managers were found to put most of their efforts. Education and development, change

management, strategy, data management and quality management were also highlighted but not to the same extent.

A model was designed following this study. The model summarised what Medical Managers do. (see Figure 2.2).

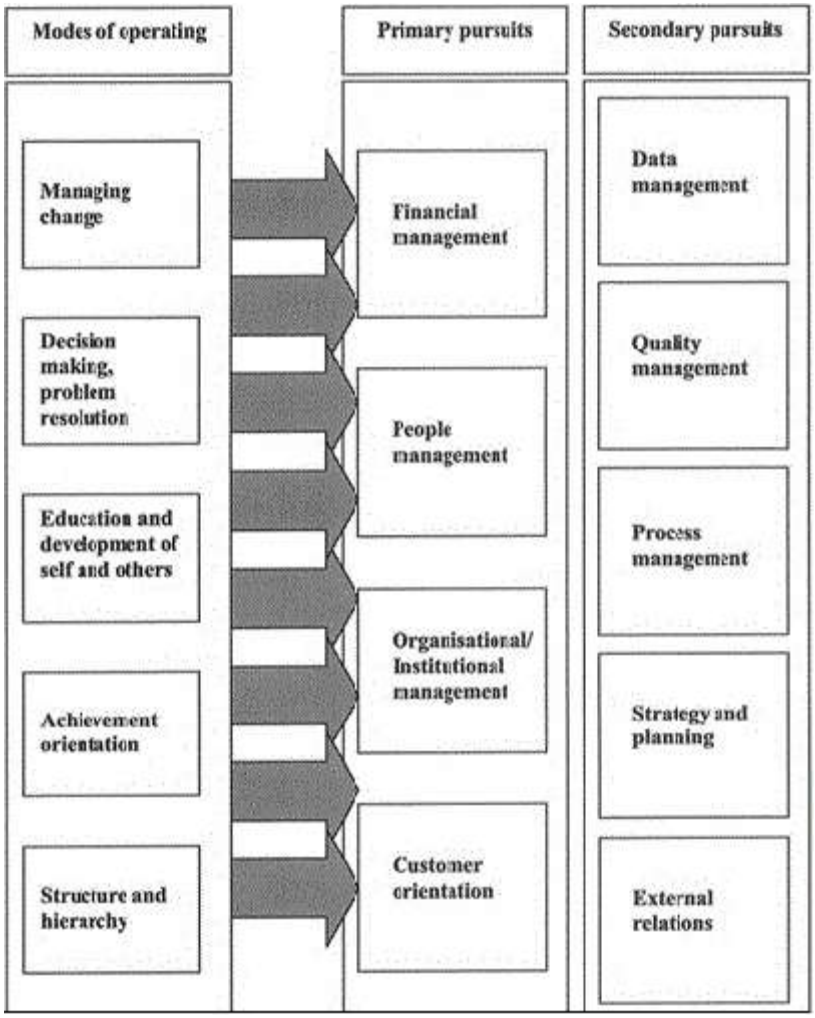

Figure 2.2 Clinician-Managers' Behavioural Routines: Major Modes of Operating and Primary and Secondary Pursuits. (BRAITHWAITE, J. 2004. An empirically-based model for clinician-managers' behavioural routines. *Journal Of Health Organisation And Management,* 18, 246.

According to (Braithwaite, 2004), the main areas on which Medical Managers spent their time included managing change, making decisions, resolving problems, education and training of self

and others, achievement orientation and structure and hierarchy. Modes of operating were defined as the methods that Medical Managers used to undertake or perform their tasks within primary or secondary pursuits. Secondary pursuits are also important tasks but are only secondary to the major or primary pursuits. Secondary pursuits were defined as data, quality and process management, strategy and planning as well as external relations. One can deduce from these studies that the only real change in the Medical Manager role that might have occurred over the years, has been the change in environment as a result of the gradual increase in disease burden both in the First World and Third World countries. In other words, the healthcare environment has changed because healthcare reforms have had to adjust to the changing demands placed on healthcare organisations including the effects of globalisation on healthcare. This change has resulted in the non-negotiable demand for healthcare organisations to do more with fewer resources and to adjust to compete on a global scale. This adjustment could possibly be the most challenging change to manage.

According to a model that was developed by (Mintzberg, 2002) on what healthcare managers actually do, it was found that managers communicate, control, lead and link (Braithwaite, 2004)).

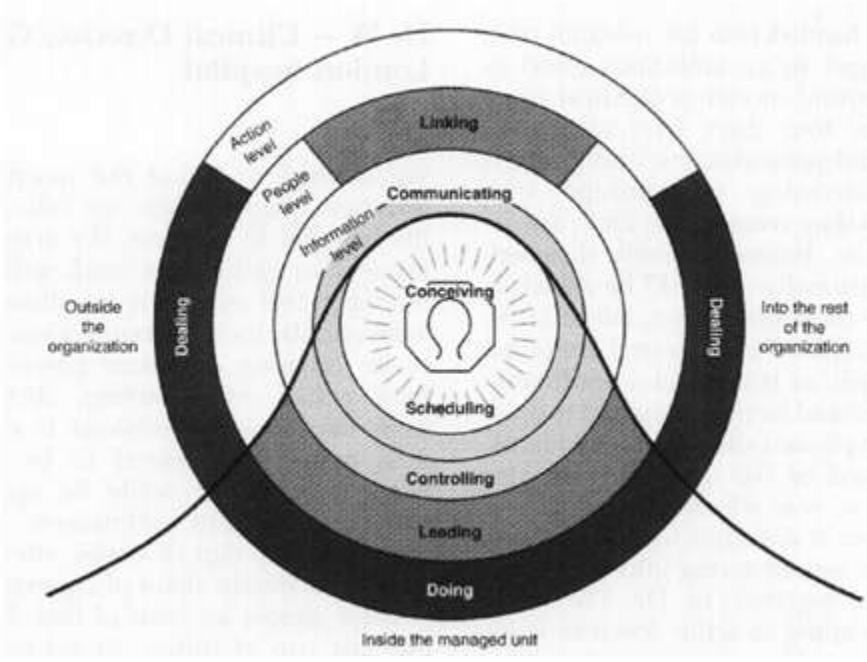

Figure 2.3 A Model of Managerial Work (MINTZBERG, H. 2002: PAGE?). Managing care and cure –up and down, in and out. *Health Services Management*

***Research: An Official Journal Of The Association Of University Programmes In Health Administration / HSMC, AUPHA,* 15, 195.**

Elaborating on these tasks in the model Mintzberg said,

- Communicating: Communication with people inside and outside the organisation. In the case of Medical Managers this would be both manager colleagues and medical staff as well as various stakeholders from outside who have interests in the organisation.
- Controlling: Referring to the work of manager as they use information available to them to institute certain required changes within the work environment to give out directives and implement various other changes.
- Leading: Doing what leaders do to guide and direct subordinates to help them achieve organisational objectives. Performing activities like coaching, conflict resolution and rewarding good performance either to individuals or groups.
- Linking: What is often known as networking, in this particular case this would include the Medical Manager networking with external stakeholders lobbying for the interests of the organisation. It is important to establish a network of useful contacts for the organisation. One example of this could be a Medical Manager who links with outside NGOs who can help finance certain operations in the healthcare organisation. This is a common occurrence within the South African context.
- Doing: What the Medical Manager does on a day-to-day basis. This may include directing programmes or projects, disciplining staff and supervising various activities
- Dealing: Handling and executing agreements with outsiders and engaging in negotiations and executing agreements (‘doing deals’) with outsiders (Mintzberg, 2002).

2.4 THE GAPS IN THE TRAINING OF MEDICAL MANAGERS - FACT OR MYTH?

It is said that,

> "The complexity of health service management should not be underestimated and there are a range of possible and equally legitimate ways to prioritise the way health services are delivered and what services are provided. Yet in South Africa, and in many other African countries, as human resources are limited, young and less experienced staff are promoted rapidly and may be appointed without adequate training to work as managers and policymakers in health services. These work environments are complex and are characterised by urgent, competing demands" (Fonn, 2011: 49).

The problem of gaps in the training of healthcare managers in general within the South African healthcare system context seems to spread beyond those of physician managers alone. Fonn (2011) further stated that an additional problem within the South African context is, "In South Africa, methods for how institutions of higher learning can work in strategic ways with provincial health departments is still poorly developed" (*Ibid*: 49)

On an international scale, Medical Managers seem to have at least one basic qualification in common. They all have a basic qualification in medicine as medical doctors. Depending on where one is in the world, one will find that in some countries like South Africa certain Medical Managers will possess only this qualification supported by years of clinical experience. Based on their commitment and clinical expertise they have been appointed as Medical Managers. In the South African context, when one looked at previous KwaZulu-Natal Department of Health Medical Manager position advertisements (Appendix 2), one found that a basic qualification in medicine and years of relevant clinical experience were stipulated as the only basic requirements for the position. Additional management qualifications, which were not usually specified, were always put as an additional advantage, but almost never as a prerequisite.

Confirming this view, and referring to a survey done on physician executives more than twenty years ago (Hoff, 1998: 101) stated the following about Medical Managers, "Approximately three-fourths of individuals had no formal graduate management degree of any kind (i.e. MBA, MHA or MPH)" (*Ibid:* 488). Hoff further indicated that, although the numbers of physician executives with management training of any kind were low, there was evidence in the same survey that there was a significant gradual rise in numbers of physician-managers acquiring management training. Confirming this view another study found that "consistent with what the literature suggests about physician managers in general that they are most often selected because they are good clinicians, not because they have demonstrated management skills" (Betson and Pedroja, 1989: 359)**.**

The lack of adequate training is also confirmed more recently by another author stating, "Michael Guthrie MD, MBA, FACPE says that 'most physicians have little or no business training and experience. The skills they have acquired in medicine are not easily transferable to management and leadership roles. They are quick studies in anything they want to learn, but do not always recognize the need for business education" (Glabman, 2006: 8). He further stated that, "Doctors don't always make the transition from clinician to executive easily" (*Ibid*: 8) and also "Sometimes they fail as leaders because they are unable to relate to the people they oversee, they are unable to engage and motivate others, they are more focused on the technical aspects rather than leadership and they don't see the strategic picture" (*Ibid*: 8).

One may argue that all these views imply a certain level of lack of adequate preparation of Medical Managers for their role as manager. Supporting the view that training amongst Medical Managers as part of healthcare managers is an area of priority, Parayitam, (2010) said that "decisions made by administrators and CEOs of healthcare organisations determine the relative competitiveness" of those health organisations" (*Ibid:* 174*)*

In another study that was conducted by (Sockalingam *et al* ., 2008) in Canada on psychiatry residents' perceptions of their own physician-manager training needs. Although these were not Medical Managers *per se*, they fall in line with the concept of physicians with management responsibility. The study found that there were training gaps in the management training of this

particular group of doctors. Management training needs therefore seems to be a problem that has been identified at both undergraduate and post graduate level in medical school training curricula in Canada. This is because clinician residents are doctors who have completed their undergraduate studies, and who then pursue specialist level training as residents in a particular field of Medicine or Surgery, becoming specialists in training. Management training gaps at this level are a reflection on both undergraduate and post graduate training. This problem seems to persist in the post graduate and specialist level training internationally. This was proven by a similar study done on West African surgeons (Mahmoud *et al* ., 2010). Specialist level surgeons expressed the same concern about the inadequacy of their preparation for management responsibilities as a result of their conventional medical school training.

Referring to an experienced physician executive in an interview reflecting on personal experiences in their earlier years as a physician executive without adequate training:

> "A month into what became a decade-long administrative tenure, Memorial's Director of Pharmacy asked him to resolve the issue of stolen hospital prescription pads. In one of his executive committee meetings, Slater notified physicians he was keeping the pads under lock and issuing keys to medical staff. A cardiologist at the meeting castigated him, telling him 'It was none of my damn business since I was not using prescriptions anymore,' Slater recalls. A shouting match ensued, something he thinks would not have transpired under the same circumstances today, now that he has 11 years administrative experience and has completed an MBA." (Glabman, 2006: 6).

This example seems to be demonstrative of the dilemmas of managing difficult professionals within very complex organisational dynamics without adequate training or preparation. It is also testimony to the belief that there is a need for physicians to undergo management skills training before taking on the physician executive role. The general lack of experience and relevant management training is again affirmed. According to Kippist and Fitzgerald (2009: 643), "One area of change in health care organisations has been the introduction of the hybrid clinician manager". They go on to say that,

> "This dual role has a divergent set of objectives that require individuals to navigate between achieving clinical and managerial objectives. However, we suggest that this may

not always occur readily for a range of reasons, such as lack of management education and skill, time pressures and personality factors" (*Ibid*: 643).

In their study, Kippist and Fitzgerald (2009: 646) further stated that, "Some hybrid clinician managers report that their poor understanding of the philosophies of organisational management and lack of management training impedes organisational strategic planning (King *et al* ., 2004; Iedema *et al* ., 2003)". Kippist and Fitzgerald (2009), also found that, although Medical Managers could identify their need to undergo management training, they were not always likely to enrol for such training and that within the management team, Medical Managers are often the least managerially qualified to make management decisions. As one might imagine, this weakens the perceived ability of Medical Manager as the advocate of physician interests to put forward managerially viable arguments on physician views on healthcare delivery matters. It was also said that, "hybrid clinician managers have significantly less management training than other professionals who are managers, for example nurse managers," (Kippist and Fitzgerald, 2009: 647).

In the same study Kippist and Fitzgerald (2009) quoted various Medical Managers on their views on their role as Medical Managers, one was quoted saying that, ". . . I was a very reluctant leader, because I am a medical doctor. We have no formal training in management" (*Ibid:* 649). Kippist and Fitzgerald also reported that the impression that the interviewees gave was that they felt ill-prepared for their role as Medical Manager because they had no formal management training. However, they felt that the work of Medical Manager could be done if one had the knowledge and skills to do so. Some Medical Managers stated that they had not had the slightest exposure to management training at all and yet were expected to work as managers. This further confirms the view that management training is broadly lacking amongst physicians and has been the case for years. The notion of physicians being thrown in at the deep end of management responsibilities and being expected to swim for themselves seems to have been more the norm than the exception.

In another study by Edwards *et al* . (2003: 609) it was found that, "there is a mounting body of evidence that badly managed organisations fail patients, frustrate staff, deliver poor quality care

and cannot adapt to the rapidly changing environment in which they operate". Referring to findings of two healthcare enquiries done in Australia i.e. the Bristol Inquiry and the Climbie Inquiry, said that the overall conclusion of these enquiries was that " poor management practice is at least as lethal as poor clinical practice" (*Ibid*: 609). Dwyer further stated that healthcare management system failures were the result of poor clinical governance and the lack of management of medical staff issues specifically the management of medical staff competence, performance management, credentialing and scope of practice. These are areas that fall within the roles of Medical Managers as highlighted by the studies already reviewed.

This highlights the specific areas of poor medical management which speaks to Medical Manager training problems. In a study on "What doctors and managers can learn from each other" conducted by (Smith, 2003: 611) which agreed with the view that doctors need to undergo additional training prior to taking on management roles it was stated that:

> "Increasingly doctors work in teams and large complex organisations. The ways of thinking and working that served doctors and patients well in much simpler circumstances are no longer enough. Doctors need to learn to think strategically".

Also, "Uncomfortable with the abstract, doctors tend to be reactive-driven by science and suffering." (Smith, 2003: 611). In relation to doctors and their views on leadership, they stated that, "Doctors think it almost conceited to set paths and are uneasy with motivating people-something that depends more on emotion than reason." Smith also believed that doctors are "Losing out in modern healthcare systems because of their discomfort with leadership, strategy, systems thinking, negotiation, genuine team working, organisational development, economics, and finance." (*Ibid*: 611). Fulop and Day (2010) stated that Medical Managers become Medical Managers by default and therefore often do not invest in their careers as managers. They often lack the commitment, the knowledge and the skills needed to fully perform the role required of them. These result in them finding difficulty in securing the kind of respect and professional independence they desire. Within management teams in hospitals, Medical Managers also seem to face challenges of credibility due to their training gaps as also stated in another study, "Managers were reluctant to recognise the clinical directors' claims to managerial jurisdiction

through the authority of their role as clinical directors because they lacked managerial expertise in areas such as budgeting" (Thorne, 2002: 18).

Pointing out the widely shared views on the need for leadership in healthcare organisations, it was said that "As the business of medicine becomes more and more complex, the need for qualified physicians to participate in the leadership of the medical enterprise is keenly experienced by many healthcare organisations" (McAlearney *et al* ., 2005: 11). Also in reference to physicians, Mclearney said "Clinical training and experience typically provide an insufficient background to enable these individuals to lead healthcare organisations or large group practices." (*Ibid*: 11). This explains why physicians fail to adjust from an individual patient-orientated view of healthcare to a broader organisation-orientated view of healthcare where resources are managed for the benefit of a broader stake-holders' benefits. They recommend the need for a cultural shift amongst physicians, that this shift should be applicable to all trainings of doctors. It becomes clear that the view that clinical training in most medical schools focuses on the clinical aspects of patient care and does not seem to consider the responsibilities of the clinician as a manager within healthcare organisations and therefore no real training in management skills seems to be taking place in most medical schools. (Vera and Hucke, 2009: 71) further attested, "Physicians are trained and socialized according to professional values and norms that are considered to be the antithesis of a managerial orientation.

Referring to physicians as managers it was stated that, "Typically they receive little preparation for the management part of those jobs" (Avakian, 2010:14). According to Avakian, by the time physicians are appointed as physician executive they have had years of experience as clinicians used to very different work dynamics. As physician they are used to being listened to, being in-charge and admired for their clinical expertise. They enjoy a lot of respect from both their patients and colleagues. Avakian argues that however, they would have received very little, if any management training. They are used to working individually or if in teams, they would be at the top of the command chain giving instructions. Experience in collaborative work and the art of achieving results through other people that is needed in the Medical Manager position is often lacking. Avakian recommends that some training is needed saying that "They need to unlearn

those autocratic behaviours, perhaps even the ones that made them very successful as doctors" (*Ibid:* 14).

2.5 THE GAPS IDENTIFIED IN THE TRAINING OF MEDICAL MANAGERS

In a study that looked at ways that a physician executive can improve on how he/she communicates with his/her subordinates and fellow executives, it was said that,

> "Managing people is a difficult process. It requires an executive who is interested in others and their views, rather than one who cares only about trying to get others interested in them, in their views and in implementing their decisions. Managing people requires an executive who is as intent on understanding the other person as on influencing the attitudes and behaviours of the other person. To carry out this difficult process effectively requires an astute manager, one who reinforces confidence in others rather than who is intent upon proving to others how competent and confident they are" (Thompson, 2005: 37).

In their study Braithwaite (2004:255) stated, "We have seen how management activity in clinical units is heavily social, centres on discourse, persuasion and negotiation, and involves working with and influencing individuals and groups and in turn being lobbied and influenced". They supported the importance of the development of interpersonal skills at individual and group levels as well as the development of technical, managerial and professional skills. To understand where the training gaps of Medical Managers are, one will need to understand all the management responsibilities of Medical Managers. In other words what Medical Managers do as their manager role at work?

2.5.1 The United States' Healthcare Leadership Alliance Competency Model

The United States has been amongst the countries at the forefront in the developments of new thinking within the field of medical management. In a study done that looked at "Common Competencies for All healthcare Managers: The healthcare Leadership Alliance Model". The healthcare Leadership Alliance defined as "a consortium of six major professional membership

organisations" (Stefl, 2008) within the healthcare field in America. The six members of the alliance were listed as:

- American College of healthcare Executives(ACHE);
- American College Of Physician Executives (ACPE);
- American Organisation of Nurse Executives (AONE);
- Healthcare Financial Management Association (HFMA);
- Healthcare Information and Management Systems Society and
- Medical Group Management.

The study looked at the formation of a common competency model developed by the alliance following the review of each member credentialing and certification process for its membership. Defining what certification programmes are, it was said "Certification programmes are designed to ensure that individuals in a professional position meet basic educational, skill, and/or experiential requirements of their respective profession" (Stefl, 2008: 363). A set of overlapping and complementary competencies were then clustered into five competency domains which constituted the model (Figure 2.4).

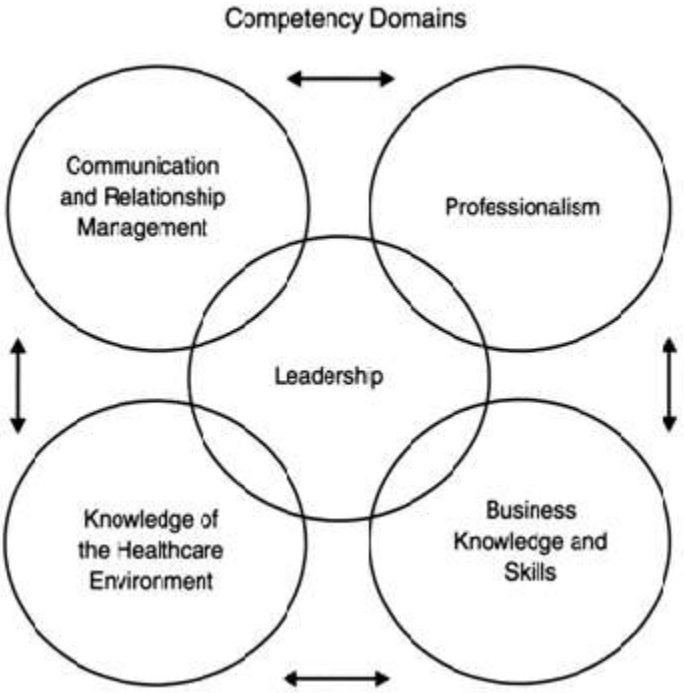

Figure 2.4 The Healthcare Leadership Alliance Model (STEFL, M. E. 2008: PAGE?). Common competencies for all healthcare managers: the healthcare Leadership Alliance model. ***Journal Of healthcare Management / American College Of healthcare Executives,*** **53, 365.**

The components of the model were elaborated as follows:

- Communication and Relationship management: The ability to communicate clearly and concisely with internal and external customers, to establish and maintain relationships, and to facilitate constructive interactions with individuals and groups

- Leadership: The ability to inspire individual and organisational excellence, to create and attain a shared vision, and to successfully manage change to attain the organisations strategic ends and successful performance

- Professionalism: The ability to align personal and organisational conduct with ethical and professional standards and that include a responsibility to the patient and community, a service orientation, and a commitment to lifelong learning and improvement

- Knowledge of the healthcare Environment: The demonstrated understanding of the healthcare system and the environment in which healthcare managers and provider function.

- Business Skills and Knowledge: The ability to apply business principles including systems thinking, to the healthcare environment, basic business principles include (a) Financial management, (b) human resource management, (c) organisational dynamics and governance, (d) strategic planning and marketing, (e) information management, (f) risk management and (g) quality improvement.

Stelf (2008: 364**)** summarised the model as follows:

> "Because leadership competencies are central to a healthcare executive's performance, the Leadership domain anchors the HLA Model. All other domains draw from the Leadership area, but the other competencies also feed and inform leadership".

He further explained that, “the two way arrows outside the circles indicate that the four domains draw from each other and share overlapping KSA’s.”Stefl further stated, “While ‘competency’ can be defined in a variety of ways, the Task Force adopted a definition ...Competencies are clusters that ‘transcend unique organisational settings and are applicable across the environment’. That is, the domains identified by the Task Force are generic and demonstrable.” (Stefl, 2008: 364). The key skill areas are highlighted as indicators of what skills Medical Managers need to master. In their inability to master these identified competency areas, Medical Managers would therefore have gaps in required training as healthcare managers.

It was said that “Common reasons physicians fail as managers include inadequate appreciation of the job requirements; inability to prioritize and complete tasks on time; inability to accept or respond to constructive criticism; lack of involvement in nonmedical services and operations; failure to communicate effectively; and indecisiveness, insecurity, or lack of self confidence.” (Lazarus, 2012: 292). Another study that supported the importance of communication between managers and physicians by recommending amongst other strategies to reduce tensions between physicians and manager was that “Communication between hospital managers and doctors should be greatly increased.” (Thomas *et al* ., 2004: 266), therefore further stressing the importance of the ability to communicate as a manager supporting the HLA Competency Model.

Defining a leader it was said, “A good leader has the ability to assemble, motivate, support, and depend upon teams. You must demonstrate purpose, passion and respect, and must develop trust by conducting yourself with fairness, integrity and consistency. You will be judged by results, which will be delivered by your teams” (Kaplan, 2006: 17). Kaplan (2006) stressed the importance of ‘refining negotiation and relationship skills’ and that “A quick transition from autonomous, decision-making, self-reliant physician to team player is mandatory” (*Ibid*: 18). Similarly in another study referring to their findings it was confirmed that “Interpersonal and communication skills, professional ethics and social responsibility were defined by these survey participants as the most important leadership core competencies” (Henochowicz and Hetherington, 2006: 184). Further stating that “One leadership competency that has been identified is the ability to coach others. Health care executives need to be trained in the discipline of coaching in order to more effectively manage others.” (*Ibid*: 188).

2.5.2 Slovak Republic Perspective

In a study done in the Slovak Republic on the "Assessment of management education and training for healthcare providers in the Slovak Republic, their survey produced resulted as highlighted (Appendix 4). The study presented areas of training need for two categories of healthcare managers as highlighted. The study separated its findings into two, results from the whole group of healthcare managers and then results from health professionals or medical trained healthcare managers within the group. According to the findings of this study, when one looked at average scores above 3.5 on a scale of 1 to 5 as a reflection on a general consensus on the importance of that particular topic for training.

Looking at results from health professionals only, topics falling under Managing change category i.e. implementing change policies, preparing staff for change and the role of leadership in change management received the highest average scoring from medical professionals. These were followed by topics under Management of organisation change with topics on introductory learning programme in strategic management and planning, organisational change strategies, working with government policies, working with municipal policies, working with new technology, identifying managerial problems in Slovakia. These were followed by topics in Human resource management relating to staff selection, guidance, appraisal, managing poor performance, staff training and skill development, improving internal communication, job design, managing staff morale, occupational health and safety. Other topics that received high average scores were quality control for operational services in hospitals under operational management, information technology and using computers, information systems for hospital administration were highlighted.

2.5.3 Medical Managers and their Sources of Power

Based on numerous years of experience within healthcare, (Blattner and Wenneker, 2005) recommend that healthcare leaders need to understand their sources of power. They say that due to the complexity of managing healthcare professionals in an environment where direct authority is not always possible, healthcare leaders need to understand where their sources of power come

from and master the art of strengthening those power sources. For an example, how to influence the actions of physicians who work within clinical units, where head of clinical units have direct authority. They define five sources of power for healthcare leaders, these are:

- Connectional Power – defined as perceived power based on perceived connections with powerful figures in the organisation for an example the Chief Executive Officer;
- Informational power –power derived from the leader's access to information that may be deemed important by the person that the leader is trying to influence;
- Coercive and reward power - the power derived from the leaders ability to make things easier or more difficult for the person that the leader is trying to influence;
- Referent power – power from being a role model, the desire that those the manager wants to influence have to emulate that particular manager as an exemplary figure and
- Expert power – power derived from the perceived possession of certain expert knowledge that is respected by the person the manager wants to influence.

These are the powers that, according to (Blattner and Wenneker, 2005), healthcare leaders need to cultivate and strengthen in order to achieve success in influencing the practices of healthcare professionals. It seems that these are strengths that healthcare leaders need to cultivate to a significant extent through adequate training and over years of on the job experience. They talk of the importance of the ability to frame new initiatives into context so that all individuals that the leader seeks to influence understand what is in it for them. Saying that with every attempt to influence others, the leader needs to master the ability to prepare a persuasive argument that will help clinicians understand why they should go through the trouble to participate in the initiative. They also emphasise that to get physician buy-in, physicians need to be included as much as possible and also need to be continuously engaged about happenings within the organisation in order for them to understand what needs to be done and why it's important. This is in line with communication skills mentioned by the other studies reviewed.

There seems to be a general agreement that gaps in the training of Medical Managers are mostly in the management preparation of physicians for the role as Medical Manager. The greatest importance is placed on leadership, the ability to communicate, the ability to manage effectively through mastering general management skills and concepts. Emphasis is also placed on a culture

shift from an individualistic approach to healthcare problem solving to a more organisational or broader approach to solving healthcare problems.

Expanding on the meaning of leadership it was stated, "Leadership discourse says that leaders matter, leadership is important, that meaning, motivation, and a sense of direction within a working life is the result of leadership. It is the significance of leadership that makes people who are in focus of the manager's attention, feel visible, respected, important and –in the next step- inclined to be team members and good corporate citizens" (Alvesson and Sveningsson, 2003: 1455). This highlights the importance of developing leadership skills for Medical Managers, especially their role as mangers has been said to be based on their ability to influence those they manage. In making an effort to understand training gaps in the training of key leaders in healthcare organisations such as Medical Managers, it is possibly the first step towards the realisation and unlocking of each organisation's full potential, as leaders and managers guide and motivate staff on the path to achieving organisational objectives.

2.6 THE RECOMMENDED TEACHING METHODOLOGY FOR MEDICAL MANAGERS-THE LITERATURE

2.6.1 A Balanced Approach to Training

Internationally, there seems to be a consensus on there being a training gap in the preparation of Medical Managers for their role as managers. There have been recommendations that the training should not be skewed towards the manager part of their role only but that the balance must be struck in their training both as managers and as physicians. There seems to be a certain level of indirect consensus in the literature that the clinical training is not the biggest challenge. This is deduced from the almost exclusive concentration of available literature on the management training gaps of Medical Managers with almost no real in depth discussion on their continuous clinical training. Where clinical training is mentioned, it is for the fact that the clinical training is important mostly to assist with maintaining certain levels of legitimacy of the clinical managers' views as a clinician amongst other clinicians and therefore encouraging acceptance of the Medical Manager as a worthy manager of the professionals within the profession. Literature

recommending how training should be delivered to Medical Managers also focuses on the management aspect of their role.

According to (Mo, 2008), balancing the development of physician executives between management training and clinical training is important. As the struggle for legitimacy is not just with management colleagues alone but the struggle is just as intense with their medical colleagues as well. So the argument that medical management is two careers in one seems to be a valid observation. Literature available has numerous studies and recommendations on management training needs of physician executives and how to train them. However, there seems to be very little research on the further clinical development of physician managers as physicians who practice clinical medicine and secondly still have to guide the clinical practice of other senior physicians. One might argue that Continuing Professional Development is already well developed within the medical professions and that such need doesn't really exist and therefore to make recommendations or do research on the matter is not necessary. Others might argue differently, this might be a topic for a whole other study.

The findings of another study in relation to physician leader training was that "the goal for a healthcare organisation in training and educating the physician executive should not be to get them reoriented to serving it exclusively but to foster a balanced sense of identification with a variety of interests that have a hand in determining whether the organisation is successful" (Hoff, 2001: 104). It was also recommended that "In order to function as liaisons between rank-and -file doctors and the organisation, these individuals must be viewed by both entities as legitimate"(*Ibid*: 92). In other words affirming the view that there is a need for a balanced approach to training for the individual parts of the dual role of Medical Managers as physician and as manager. It has been said that one trait shared by most physician executives that counts to their favour is that as physicians, for them learning is a way of life. Therefore training initiatives should be well received as stated, "although working conditions vary widely around the world, health professionals share common features: they are highly educated and eager to continue their professional development throughout their working lives" (Straume and Shaw, 2010: 392).

2.6.2 The Healthcare Organisation's Responsibility

In another study titled "Healthcare Managers' Perceptions of Professional Development and Organisational Support", referring to continuous professional development, it was stated that organisations that adopt a learning culture termed "learning organisations", these organisation don't rely on random unplanned learning but "actively promote, facilitate, and reward collective learning" (Gumus *et al* ., 2011).Stating that such organisations view learning as a culture. The learning culture is adopted for the purposes of improving performance, productivity and profit. Shifting the responsibility for training partially to the organisations. Referring to learning organisations, these organisations learn to master five activities, "systematic problem solving, experimentation with new approaches, learning from their experiences and past history, learning from the experiences and best practices of others, and transferring knowledge quickly and efficiently throughout the organisation " (Gumus *et al* ., 2011: 44). Implying that the learning culture is important as a precursor to employee and manager culture of continuous professional self-development.

They further stated that for these organisations to master these activities it is argued that these organisations need to learn how to tap into the commitment of its members and their capacity to learn at all levels of the organisation. These organisations view both individual and group development as pivotal to the success of the organisation. A learning organisation "promotes, facilitates and rewards learning" (Gumus *et al* ., 2011: 44). This implies that Medical Managers' inclination to learn and engage training initiatives positively is possibly significantly influenced by their organisation's culture around learning (Gumus *et al* ., 2011). This view shifts some of the training responsibility away from the individual manager to the organisation in which they work. Referring to learning at an individual level i.e. Personal Development (PD) Gumus *et al* .,*)* (2011) stated that "Individual level PD is also recognized as critical to healthcare management by the American College of healthcare Executives (ACHE) as well as other professional organisations in the field" (*Ibid:* 44).

2.6.3 Continuous Professional Education System

According to (Gumus *et al* ., 2011), organisations such as ACHE fellowship require professional commitment and continuing professional development in actual relevant education hours. This being another method of ensuring that relevant and much needed training is continuous amongst Medical Managers. Remarking further in relation to physician executives as "knowledge workers" said,

> "Their greatest potential limitation is obsolescence. Due to rapid changes not only in the health industry but also in the global environment, the knowledge worker appreciates that learning and work are not distinct. Success in the work of healthcare managers means keeping current with developments in the field and also keeping personal knowledge, skills and competencies current through PD" (Gumus *et al* ., 2011: 45).

Despite this emphasis on the importance of learning as a culture at both individual and organisational level, Fulop and Day (2010: 344) said that "Many 'leadership' programmes in health (and other areas from which health borrows) fall into what could be described as the 'sheep dipping' trade". Sheep dipping is defined as a random selection of leaders for random training that is extremely widely spaced, unplanned and without follow up on training continuity or effectiveness. Manifesting traits opposite to what a learning organisation has been defined to be. This approach to leader training is also said to mostly focus on leadership training on an individual versus leadership training as a broader shared responsibility between various strategically selected individuals within an organisation.

Leader-centred development is also highlighted by Alvesson and Sveningsson (2003). Further critiquing leadership development focused on an individual versus that of a shared leadership approach, Jackson (2003) in Fulop and Day (2010: 345) stated that "Critics of leader development approaches point to the dangers of the self pre-occupation that emerges with the focus on the qualities, attributes and competencies of individual leaders helping to propagate a cult of 'self-development', 'self-awareness' and 'self-improvement' to solve significant organisational challenges that are usually beyond the remit of anyone person" .

Bringing attention to certain important details to be observed in the training of Medical Managers Gleeson and Knight (2008 in Fulop and Day, 2010) further stated , "When considering the context of the clinician manager, the framing must also account for the tensions and conflicts that shape notions of leadership as a professional process" Fulop and Day (2010: 346). Meaning that the training of Medical Managers needs to include the preparation for the tensions that they should expect as part of their experience as leaders which will strengthen and shape their on the job learning process.

In their study, Fulop and Day (2010: 346) explain that this actually meant that medical management as a profession-based leadership is constituted by "highly qualified reluctant leaders who do not see management as a career goal and further have to work within systems that fail to engage them effectively to harness their great potential". Fulop and Day feel that most of the research on medical management that has influenced Australia comes from the UK and has also been mostly leader centric in approach, expressing a level of disagreement with this approach. Focusing on an individual leader development versus the broader shared leadership approach, where training initiatives are directed to a broader group within the organisation. Stating that this type of approach to leadership often proved difficult to put into practice referring to the work of Smith and Eades (2003 and Hamlin, 2002 in Fulop and Day, 2010: 347) "This leader-centric approach is instrumental in its orientation and prescriptive in its purpose, and often devoid of any accounts of how these approaches can be universalised from one context and country to another".

2.6.4 The United Kingdom Perspective

Referring to leading approaches in leadership development in healthcare in current times, Fulop and Day 2010 made reference to two specific approaches currently being utilised within the United Kingdom context. The NHS Leadership Qualities Framework (LQF) and the Transformational Leadership Questionnaire (TLQ). The LQF is said to comprise of three clusters of leadership qualities which are seen as critical to effective healthcare management and delivery therefore a focus of training initiatives. These clusters are:

1. Personal Qualities: This includes self-belief, self-awareness, self-management, drive for improvement and personal integrity;
2. Setting Direction. Leadership qualities relating to direction-setting are: seizing the future, intellectual flexibility, broad scanning, political astuteness and drive for results and
3. Delivering the Service, comprising: leading change through people, holding to account, empowering others, effective and strategic influencing and collaborative working.

The LQF is focused on the individual leader and the development of their skills in leadership. The LQF is said to have been designed to epitomize leadership behaviours and traits of a leader. The TLQ was said to be "one of the most well-known leadership tools in the UK" (Fulop; Day 2010). It has 14 themes or characteristics arranged into three broader themes: (1) Leading and developing others; (2) Personal qualities; and (3) Leading the organisation." (Fulop and Day, 2010). These two approaches to physician manager leadership development have been used to focus healthcare Leadership training initiatives. Although it has not been specified exactly how these competencies are actually taught.

2.6.5 The Australian Perspective

According to Fulop and Day (2010), two important skills that good leaders learn and master in the work place from repeated experience on a day to day. These skills were termed The "Gambit of compliance" and "Organisational acumen". Defining these Bittner in Fulop and Day (2010: 349) said, "The 'gambit of compliance'… requires that considerable experience and skill be used to legitimately accomplish this kind of work. Knowing which story to tell, which figures to use and which stakeholders to communicate to". They say that these skills are learnt through repetition, exposure to both failures and success, until one gets the feel for what works and what doesn't work in influencing subordinates and colleagues to meet certain objectives within the workplace. A good example would be the use of available data to justify why a certain cheaper drug should be used versus another more expensive option for a particular medical condition.

A similar strategy could be used arguing for the justification of certain expensive clinical decisions to management colleagues. The presentation of financial data together with clinical

research findings supporting that argument, in order to persuade various stake-holders on various issues of interest is a good example. They say that this is an activity and skill built up by managers over time. They argue that these are the activities through which leadership is refined. Defining Organisational acumen as "part of what entitles the leader to interpret rules and procedures to suit certain ends" (Fulop and Day, 2010: 349). In a way these activities are related with how to put forward a convincing story to get the buy-in from those one leads or works with. These concepts speak to informal learning processes within healthcare organisations as a form a method to teach managers what they need to learn to manage more effectively.

In training leaders one needs to bring understanding into how some of the necessary skills are acquired through processes of trial and error, success and failure perfected over time (Fulop and Day, 2010). In training leaders, emphasis is made on the value of the hard times during early career days that leaders should embrace. They need to embrace the initial hardship and feelings of complete loss as these negative experiences are believed to be important building blocks of a good leader. The feeling is that these initial experiences are not researched enough in the literature for leaders to systematically learn from them but a suggestion is made that these experiences could be invaluable in leadership training efforts. Meaning that during the initial phase of trials and failures, managers should understand that in time the skills will be perfected and accept the failures as lessons. Fulop and Day believe that health departments' response with tailor made medical leadership training programmes targeting their own managers to address training gaps may still have short comings. They propose that a very critical question be asked as to, "what kind of leaders are we developing? What approach are we using to ensure that the work of leadership gets done in ways that clinician managers can relate to" (*Ibid*: 349).

2.6.6 Views from Various Other Studies

According to Simmonds *et al* ., 2001, managers acquire management concepts in three ways. Through experience, involvement and association, and education. They define involvement activities as being activities like staff meetings, interaction with outside academic and non-academic consultants and company protocols. They found that 72, 9 percent of learned strategic management concepts are acquired through experience and 23, 2 percent through association. In

their study (Simmonds *et al* ., 2001: 369) stated that "Personal experience is believed to be the genesis of organisational learning". Direct education through direct formal teaching e.g. personal study in the scholarly world and personal college education were found to be the smallest source of learned strategic management concepts for managers. This would be in-line with previous views of on the job learning. Learning through association was defined as interaction with business peers inside the organisation and outside. Learning from intra-organisational peers was found to contribute more than peers from outside one's own organisation. This means that networking with colleagues is a valuable and recognised method to augment training interventions. Encouraging networking between managers and their colleagues is therefore a way to augment learning.

In the study by Simmonds *et al* ., (2001), they bring the argument of Continuing Education Units (CEUs) that other professional groups like doctors use to keep up with latest developments, with current thinking in their fields of work. They argue that this might be a source of knowledge that could contribute significantly to the manager's knowledge pool. Saying that "It is reasonable to expect (as we found) that managers seeking continuing education through readings, workshops, or seminars would gain greater knowledge of current academic concepts" (Simmonds *et al* ., 2001: 370). This has been the current trend internationally in various professions including medical professionals in South Africa. These professions have all identified the importance of its members keeping up to date with current innovations and practices in their professions. They argue that this is a missing intervention within management as a profession.

One may than deduce that, like in America where Medical Managers have formed Colleges with Fellowships, that for a CEU programme to be implementable there needs to be a joint effort from its prospective members to form such bodies and advocate for the formation of CEU programmes. They suggest that there is evidence that familiarity with concepts is increased by recent CEU activities. In their study they also found that respondents (who were not from healthcare organisations) spent very little time consuming academic general business management magazines that introduced current thinking in the field of management to keep abreast with current general leadership and management recommended practices. This was found to be one of the possible reasons why formal education contributed the least to the acquisition of

strategic management concepts by managers in general. One may argue that Medical Managers like other managers in other organisation outside of healthcare could benefit from this type of management concept resources.

2.6.7 The Motivation to Change-Leadership Development Context

According to Harris and Cole (2007) an individual's motivation to learn plays an important role in the success of the training offered. They define two stages that prospective learning programme attendants would usually be categorised, prior to commencing training. The stages are related to level of motivation to engage in the training. The one stage is termed the pre-contemplator stage. At this stage the individuals show poor insight or lack of awareness into their own need for training that is offered. They might have been passively enrolled into the training programme by their organisation. They find attendants at this stage to be associated most often with organisational culture that doesn't encourage continuing self-appraisal and learning, there is a very low level of self-awareness of personal training gaps. Therefore this stage is related to poor training outcomes and poor ratings of training initiatives. The Second stage is termed Contemplator stage. These individuals are quite aware of their training needs and therefore are more likely to have a generally positive attitude to the learning initiative and a more positive learning outcome is usually observed.

In contrast to the pre-contemplators, contemplators are generally associated with organisations who adopt a culture of continuous appraisal and learning therefore improving self-awareness of training gaps or needs amongst its workforce. It is then proposed that any trainer or training programme or initiative should ascertain at what stage their trainees are prior to the beginning of each training initiative. Proposing that all attendants of planned training should ideally be assisted to get to the contemplator stage prior to initiating the training for the best possible outcome. They propose that this is done through raising consciousness to the need for training before beginning the training. Stating that "Generally motivation to learn is conceptualized as exerting its influence through a participant's decision-making process regarding the direction, focus, and level of their effort to participate in the development activity" (Harris and Cole, 2007: 775). According to this view, this implies that in the context of this study, for Medical Managers to be trained effectively, they need to be aware of their need to learn first.

(McCall (2004 in Harris and Cole, 2007: 789) also concur with the view that "In fact, in the realm of leadership development, classroom training is increasingly regarded as least influential while actual experience (e.g. on-the-job training) is considered the most influential". Arguing that pre-contemplators, through experiential on-the-job challenges, might have their awareness for training needs raised to contemplator level. Possibly to a certain extent supporting the 'thrown at the deep end experience' that some of the Medical Managers previously highlighted.

One would hope that as much as leaders can be thrown at the deep end, organisations realise that they cannot afford to ignore the urgent need for preparation of Medical Managers as managers of physicians who have a huge influence on cost containment initiatives within healthcare facilities. There is also emphasises the aspect of the organisation's role in the development of a learning culture that will help the development of more contemplators and fewer pre-contemplators. It's proposed that organisations can achieve this through the adoption of a permanent culture of continuous performance appraisal and learning. This requires a whole culture shift within an organisation and a commitment from organisational management.

2.6.8 Medical Leadership Development Programmes

According to McAlearney *et al* ., (2005), more and more organisations are now opting to design their own physician leadership development programmes that are tailored to the specific needs of their own organisation and their own physician leaders. This is said to be done because the ultimate purpose of training such leaders is to meet the needs of the specific organisation and its work force. They refer to one specific Medical Leadership Programme at Columbia Children's Hospital, in the United States. They analysed how the programme was put together, the curriculum design, its implementation and the organisational support that was required to ensure the programme was a success for both the organisation and the clinicians who attended the training. The first step that the process went through was the recognition of the learning culture differences between leadership training and clinical or medical training. The plan then became that of bridging these gaps so that physician leaders could fill those gaps that were detrimental to their success as leaders. Table 2.8 summarises this process.

Table 2.8 shows the conflicting cultures between medical and leadership training. The table than shows the training programme that was developed for each and every training gap identified as tailored for the Columbia Children's Hospital physician leaders. This serves as an example of an approach that has been proven to work and that proved to be quite popular amongst the clinicians that were involved as reflected by the post training survey of the training impact on the trainees. The training was thought to be relevant and addressed the needs of both organisation and trainees. Mclearney concluded that "The transformational change required for physicians to develop and appreciate business and leadership skills and styles can be supported and encouraged in a leadership development programme that includes the components of careful curriculum design, programme monitoring, and opportunities to apply new skills in practice" (McAlearney *et al* ., 2005: 18). Further stating that many healthcare systems are already adopting this approach to medical leadership programme development.

Table 2.8 Curriculum Development to Foster Transformational Change (MCALEARNEY, A. S., FISHER, D., HEISER, K., ROBBINS, D. & KELLEHER, K. 2005 Developing Effective Physician Leaders: Changing Cultures and Transforming Organisations. Hospital Topics, 83, 17.

Medical training fosters . . .	Administrative leadership requires . . .	MLP courses developed to facilitate this transformation
Autonomous decision making	Collaborative decision making	Leading Your Team: Creating the Consensus You Need to Succeed How Effective Teams Enact Change
Reactive problem solving	Proactive problem solving	Vision and strategic planning; Business plan development; Conflict resolution and prevention Business of Healthcare
Focus on details	Focus on system	Beyond Dollars and Cents: Evaluating Strategic Business Risk Pediatric Systems Growth—Revenue and Bottom Line Pediatric Physician Practices: Current Situation and New Horizon Opportunities
Linear thinking; analytical approach	Creative thinking; intuitive approach	Leadership as Transformational Change "First Break All the Rules: What Great Managers Do Differently"
Little tolerance for ambiguity	Tolerance for ambiguity	Dealing with Difficult People Situational Leadership
Quick decisions; quick implementation time-frame	Longer time to make decisions and implement solutions	Getting to Yes—Building Consensus Enhancing Effectiveness Through Improved Communication
Career advancement based on clinical excellence	Career advancement based on managerial success	Delegation and Accountability Coaching and Mentoring Dealing with Interpersonal Conflict in the Workplace Next Steps in Your Leadership Career
Patient-centric focus	Organization-centric focus	Mission–Vision–Values–Strategic Plan Overview Difficult Dilemmas in Practice Management
Clinical skill development	Administrative skill development	Finance for Healthcare Professionals; Cost Accounting Principles in Medical Practices Conflict resolution and prevention

Note. MLP = Medical Leadership Program.

Based on the Columbia Children's Hospital Medical Leadership Programme (MLP), for each training gap identified a course was then designed to meet the specific needs of their physician leaders. For an example, the much talked about patient-centred focus that physicians are known to adopt in their approach to patient care and healthcare management that has been said to be often detrimental to the holistic management approach to healthcare management. The Columbia Children's hospital MLP designed a course on Difficult Dilemmas in Practice Management combined with the Mission-Vision-Values-Strategic Plan Overview. In other words this course seems to have had the intention to bring into focus the broader objectives of the organisation while at the same time acknowledging the dilemmas of focusing on a patient centred approach to the detriment of the general organisational mission and objectives which aim to balance the needs of the broader stakeholdership.

Another example is that of addressing physician executives approach to career advancement based on clinical excellence. This would normally re-enforce the feelings that most physician executives have been said to have, feelings of being physicians first and managers by default. Showing physician managers how to advance a career as Medical Managers and how to advance themselves as managers, one can argue would change their view of their position as physician executives who are physicians first and start to appreciate medical management as a viable career option in its own right. In a way, this is a process of destigmatising medical management as a profession.

In a study done by (Conbere *et al* ., 2010), where an analysis of physicians' perceptions on the effectiveness of various teaching methods was done in relation to the Physician Leadership College (PLC) programme, an 18 month non-degree programme offered by the Centre of Health and Medical affairs in the University of St. Thomas's Opus College of business in the United States. This was following completion of the leadership programme. The programme used various teaching methods to teach leadership concepts. The findings were summarised as shown on Table 2.9. The founders of this programme are said to have believed that leadership training for physicians should be delivered in three stages. The first was leadership skill and concepts; the second was personal aspects of leadership and the third stage covering management skills. They stated that andragogy or adult learning theory states that methods of teaching adult learners should be different from methods of teaching children. It is stated that

since adults bring to the classroom a wealth of knowledge from their own work experience or life experience, the learning methods targeting adults should be methods that encourage or give opportunity for the application of learned concepts to their own day to day experiences. This particular programme was said to have achieved so much success in assisting physicians with leadership and management challenges that the effects of the programme even positively influenced the personal lives of physicians who got involved as assessed through trainee spouses feedback done after programme completion. The programme was first offered in the year 1999.

Table 2.9 Physicians' Perceptions of the Effectiveness of Programme's Educational Methods (CONBERE, J. P., HEORHIADI, A., CAMPION, B. & BROWN, J. 2010: PAGE 73) Preparing Physician Leaders: A Model for the Learned Professions. *Revue Sciences de Gestion*.

Educational Method		Mean	Std Dev
Lecture		3.26	0.50
Case studies		3.63	.048
Class discussions		3.87	0.33
Group work & presentations	3.38	0.62	
Simulations / role plays		3.05	0.76
Cohort conversations	3.77	0.41	
Assessment & Coaching		3.11	0.69
Mentoring	2.70	0.95	
Faculty modeling	3.07	0.67	

Physicians were asked "This teaching approach had a positive influence on the development of my physician leadership capacity."
Response scale: 1 = Strongly Disagree, 2 = Disagree, 3 = Agree, 4 = Strongly Agree

Based on the study's findings, physicians in the group showed higher levels of preference for class discussions, case studies, lectures followed by assessment and coaching in that order. To be transformational leaders, according to this study's findings, managers need to know self well. Transformational leaders are leaders who are said to lead by empowering others and encourage a shared leadership approach.

There is a view that the development of "physician leaders using a reliable and theory driven leadership model could emerge as a key strategy to accelerate the wide-spread adoption of evidence-based practices for long term cost containment and quality improvement through better practices" (Xirasagar, 2008: 600). This highlights the importance of sharing best practices in the field of Medical Leadership Development like that highlighted in the Columbia Children's hospital example. Xirasagar says that in order for the much needed innovations in healthcare to ever see light of day, there needs to be healthcare leadership to diffuse such innovations within available resources and with a wider stakeholdership interests at heart. Clinicians are known to be exceptional in what they do; they are fluent in the skill and practice of their trade but are thought to be crippled in the skills of management. The few clinicians who take up leadership roles, as Xirasagar implies, need to be strategically trained in leadership using methods that have been proven to work on the development of clinician leaders in other healthcare organisational settings.

2.6.9 Preferred Training Method-Slovak Republic

According to a study by Rusnakova *et al* ., (2004) on training needs and preferred training methods of healthcare managers in Slovak Republic the findings presented how both medically trained and non-medically trained healthcare managers preferred to be trained. Of interest in this study are the Medical professionals or medically trained managers training method preferences (Table 2.10).

Table 2.10 Preference of Particular Education and Training Methods (RUSNAKOVA, V., BACHAROVA, L., BOULTON, G., HLAVACKA, S. & WEST,

D. J., JR. 2004: 24 PAGE 24) Assessment of management education and training for healthcare providers in the Slovak Republic. *Hospital Topics,* 82.

Type of teaching methods	Total group (%)	Medical professionals (%)
Group discussion	76.7	64.3
Seminars chaired by participants	36.7	35.7
Role playing	36.7	21.4
Practical exercise	50.0	35.7
Managerial games	60.0	50.0
Written works with feedback	20.0	7.1
Short visits with instructions	50.0	42.8
Distance learning	20.0	28.6
Individual consultation with a tutor	13.3	14.3
Consultations in groups	56.7	50.0
Mentoring	0	0
Case studies	66.7	78.6

According to the study's findings the most preferred methods of training by medical professionals were Case Studies (78, 6 percent), Group discussions (64, 3 percent), followed by Consultations in groups and managerial games (both at 50 percent). The least preferred methods of training were Mentoring (0 percent), written work and feedback (7,1percent) and individual consultation with tutor (14, 3 percent). This provides some further affirmation for the already highlighted view that clinicians have been programmed to learn in a certain way through their culturisation in medical school. Learning through application of theory after formal teaching of concepts. This also affirms the view that medical leadership programmes delivered in a similar fashion as medical school training will make it easier for clinicians to learn as they have already been cultured to learn in that fashion. Other studies from other parts of the world also attest to these findings (Busari *et al* ., 2011) attest to this view when in reference to management training interventions for doctors they said "we would recommend the use of the most preferred methods of instruction, that is, formal didactic teaching and interactive teaching sessions" (*Ibid*: 195). They further state that they recommend that management training programmes should be

incorporated into all medical school curricula, with a preference noted for such training in the residency year.

According to a study by (Mahmoud *et al* ., 2010), that looked at leadership training preparedness of West African Surgeons. The survey showed that medical training did not prepare these clinicians for this role. They recommended a paradigm shift in physician views on leadership, and a 'three month long health management package'. They believe that the whole medical school curriculum should be combined with a suitable management science package. This practice is already adopted in many American medical schools as mentioned by Butcher 2011 that there are already 65 dual MD/MBA programmes being offered in medical schools in the United States. For countries like the United States to commit to whole medical school curricula changes, this move on its own speaks volumes about which direction current thinking is going. One can presume that the days for debating whether management education for physicians is necessary or not are soon coming to an end or are long over.

A study by (Gorringe, 2011) advocates for executive coaching as a means of delivering leadership training. They propose that a thorough process of performance discussion is done supplemented with appraisal and development needs analysis of individual leaders is established. This process is then followed by a development programme designed for that individual manager and a more senior sponsoring clinician or manager is assigned for continuous support and monitoring. This method however assumes the availability of enough, more senior adequately trained managers within the training manager's environment who have the skills to coach or mentor. A lot of debate around the inadequacy of training of clinician leaders within healthcare systems around the world makes one conclude that in most settings this approach might prove to be a challenge as adequate training of physician managers in these skills seems to be at discussion phase in a lot of countries. Possibly combining coaching on the job with other approaches where the teaching of theory is delivered by external consultants and the implementation through feedback and case studies could then possibly be applied in practice with some success.

2.6.10 Healthcare Departments' Role

According to (Ellis *et al* , 2011), in contrast to individual leaders seeking out their own training as judged by their own perceptions of their needs as individuals, it might be time that health departments get involved in "developing its own". Stressing that the objectives of the their Department of Health was to "place considerable emphasis on developing new leaders who are able to implement and manage change" (Ellis *et al* ., 2011: 5). They also recommend that as a strategy to deliver the required training that medical leadership programmes offered by various institutions in general should be aligned with the healthcare delivery strategy of their respective National Health Departments. This was a recommendation also made by Fonn (2011) within the Sub-Sahara African context as a strategy to improve management skills within public health institutions in the light of current problems of management skills shortages within healthcare. Ellis *et al* . support the experiential learning approach in delivering management training to doctors, stating that it "fits well with the prior learning patterns of doctors" because he says "clinical skills and acumen have for centuries been acquired in similar ways" (Ellis *et al* ., 2011: 5).

Elaborating on one programme initiated by the National Health System (NHS) in the United Kingdom that uses coaching to develop leaders. The Chief Medical Officer Clinical Advisor Scheme. The programme was piloted in 2005 and officially established in 2008 after a very positive outcome. The programme recruits doctors at all levels. Junior doctor and senior doctors are recruited and these doctors undergo a very competitive process of selection. Selection is not necessarily based on years of experience but on demonstrated leadership qualities and attitude. These doctors are then offered an apprenticeship to a senior healthcare leader. These doctors than learn under the guidance of the senior leader. They gain exposure to day to day challenges and how to approach various challenges in the workplace, "learning by osmosis" from their appointed senior healthcare leader. This is done following the formulation of formal personal development plans and appraisals with their clinical supervisor (the senior healthcare leader). It was stated that, "Clinical Advisors are given the opportunity to gain a deep understanding of the National Health System (NHS) structures, organisational culture, the public health service and

healthcare policy formation. They work in close contact with senior NHS and other leaders and gain skills in leadership, management and health policy" (Ellis *et al* ., 2011: 4).

A recommendation of a move away from leadership training focused on an individual was again supported by another author stating that "Analysis of NHS organisations reveals that professional bureaucracies do best through a more distributed approach to leadership" (Stanton and Lemer, 2011: 50). In the context of the Medical Managers' work environment one may then deduce that as Medical Managers oversee heads of clinical units, that leadership training efforts should focus not on the Medical Manager alone but also on the heads of clinical units to evenly distribute the benefits of leadership skills training and the responsibilities. As highlighted by Mintzberg, the Medical Manager supervises Heads of Clinical Unit. The view of leadership as a shared responsibility is shared by many authors. In the actual training sessions Stanton and Lemer also recommend that training that puts management trainees with medical trainees together to share in their knowledge and expertise is used as they highlight that in certain health systems this is becoming actual current practice but at a pilot networking scheme level. They feel that this practice has the potential to be extended beyond just being a pilot.

2.6.11 Learning from other Sectors

According to (Duberman, 2011) healthcare should take lesson from corporate America. They speak of the 70/20/10 rule. According to corporate America, 70 percent of leadership training or organisational learning is acquired or delivered through actual experience on the job. Explaining that, 20 percent of the training should be based on drawing lessons from colleague managers through coaching and mentoring (i.e. informal learning). According to their recommendations only 10 percent of training should be through formal learning as in classroom, workshops or e-learning. The industries are known for their often ruthless fixation on the bottom line and relentless pursuits of innovation to find best possible ways to improve efficiency and effectiveness. The suggestion is that healthcare organisations should learn from the best practices of American corporate in the training of its managers.

According to Esselman (2011), after reviewing the advice given by experienced physician executives recommended on-the-job learning. Stating that leading physician executives also got

to lead through a process of perfecting leadership skills and experience. Saying that "they broadened their focus to become valued business strategists, team members and decision makers." (Esselman, 2011: 58). This view is in line with the recommendation that physician managers should widen their sources of learning of management concepts also affirmed by (Blattner, 2010) when they said "successful executives regularly consume the general business press and literature to stay on top of new thinking in strategy, competitive positioning, and leadership effectiveness"(Blattner, 2010: 67), that like managers in industry, they should look at consuming general management readings from general management magazines over and above the formal teaching offered by their organisations or sourced by themselves from within healthcare. The suggestion is to look outside the box for innovative and inspirational approaches to management challenges. This is also in line with the CEU (Continuing educational Units) recommendation that has been recommended before, through journal readings, seminars and so forth.

2.6.12 Medical School Curricula

According to Butcher (2011), the current trend in the United States that 'at the 2010 annual meeting of Association of MD/MBA, 48 Universities were represented with three medical schools having sent representatives to learn how to add an MBA degree onto their curriculum' (Butcher 2011). In the year 2011 they state that more than 50 percent of medical schools in the United States allowed students to pursue a dual degree in Medicine and Business administration (MD/MBA). It is of interest to note that the Association of MD/MBA was established in 1997 and by 2011 more than 50 percent of medical schools had joined the association. This is reflecting an ever increasing general move towards the incorporation of the management sciences into medical training in American Medical Schools at undergraduate level. This approach speaks to the shared leadership approach where all physicians in future could have management training therefore an inclusion of management concepts and practices into every clinical decision that each and every clinician makes. Possibly partially solving the problem that healthcare managers have had for years with the self-governing nature of physician practices. The often rejected influence of hospital management in the individual day to day clinician clinical decision making processes.

The challenges often expressed in influencing physician practices would be addressed when management concepts are understood and practiced by physicians and made part of their thought processes as they weigh treatment options for each and every patient, through earlier culturisation of doctors into management and leadership thinking with every clinical decision that they make (Butcher, 2011).

2.6.13 The Nature of Physicians

In a study by (Thompson and Noelke, 2010), they believe in the inherent goodness of physicians and that its second nature for physician leaders to do the right thing. They however acknowledge that instinct alone is not enough to help them meet the demands of their challenging work, believing that for physician leaders to be great performers they require that great instinct to do the right thing plus "a challenging environment, specific training and ongoing mentoring" (Thompson and Noelke, 2010: 49). This view is also in line with the belief that learning acquired within the working environment is a source of a significant amount of the total training that managers receive. They also seem to support the value placed on leader coaching and mentoring previously expressed. Supporting the view that the learning process is an ongoing one and affirming the value of a learning organisation that encourages the creation of more contemplators and fewer pre-contemplators.

According to (Igel, 2012), as much as physicians have had the responsibility to teach themselves for centuries, for someone to learn something new it requires that one learns to listen. Stressing the importance of attentiveness and being observant, that these are the disciplines that lead to innovativeness. They argue that the attention needs to be focused on method not skill. Defining method as "Method comes from the application of knowledge to skill" (*Ibid*: 45). This means that training is important but even more so, is how that knowledge is applied in practice. Supporting the views in agreement with work based learning, the use of case studies as examples of applying knowledge to practice also stating that the ability to apply knowledge to skill i.e. method ,comes from learning from one's colleagues who worked before in the same position. Concluding that focusing on method gives managers the ability to improve individual management practices and allows them to improve on previous practices within their organisations.

2.6.14 Lessons from Successful Medical Managers

Learning from physicians who advanced their careers beyond position of physician executive to the top of the health care organisational Strategic Apex and became Chief Executive officers (Ham *et al* ., 2011). As a symbol of success in mastering the trade of healthcare management and moving up the ranks, the view was that these managers could have valuable advice to give. According to their findings, these Chief executives received very little formal training and had to learn most of what they knew from their work environment, from their more senior colleagues. Highlighting the value of mentorship and coaching on the job. Acknowledging that mentoring and coaching presented opportunities for these Chief executives to fill gaps in training as well as in experience. These individuals have been through the realms of medical management and made a success of their time there. It seemed that through dedication and focus, the willingness to receive and ask for guidance and adopting a culture of learning seemed to be the key ingredients in their success to positions as Chief Executives. These executives also noted that generally their employers took no interest in their training and development and they relied heavily on their own initiatives to source needed training.

2.6.15 Medical Doctor /Masters in Business Administration (MD/MBA)

According to (Ham *et al* ., 2011), it is important to develop clinical management as a specialty as a means of facilitating advocacy through a nucleus of individuals for issues affecting Medical Managers like training needs and other matters of similar importance. America seems to be one good example with its formation of Colleges, Fellowships and the development of training support programmes, healthcare leadership competency frameworks and involvement in research for the benefits of its members. Hence most probably the reason why it is that America is amongst the leaders in current thinking and practices in medical management. America is amongst the most advanced countries in medical management and leadership development as also evidenced by the rapid progress of the MD/MBA programmes as reflected by their incorporation of management science into more than 50 percent of their medical schools curricula. (Ham *et al* ., 2011) also refer to the need for "Discovering colleagueship" and "establishing legitimacy" within medical management as a profession as important precursors to

the development of Medical Managers and therefore unify Medical Managers in a fight for legitimising their profession.

According to Lazarus (2012), the approximated 65 medical schools offering a dual degree combining medicine with a business degree within the United States, stated that with that kind of training, management inclined physicians can start their management career even in their twenties, which hasn't been common practice before. Should this practice be adopted internationally, this has significant implications for current Medical Managers who still practice without any management training, let alone a master's degree in management. They could soon find themselves irrelevant and being replaced by much younger doctors fresh out of medical school. One might argue that this might not be the case in the light of the fact that current research is also showing time and again that learning from experience counts for much more than a qualification on a piece of paper. Even then, the possible conclusion could be that those managers who have numerous years of medical management experience need to keep up with current thinking in management concepts through continuing learning at one level or another to maintain legitimacy and relevance as professional managers. They formally or informally, need to acquire the necessary training. On the other hand some believe that formal training is still paramount. According to (Hartung, 2012), the suggestion is that for physician managers to have business credibility they must have a business degree in order for them to get the tools they need to be conversant on the management side of their job. This view one might argue might still be quite a valid argument.

According to (Dister, 2006: 14)**,** "a post graduate degree is a must", stating that a formal business qualification is a critical factor for a successful management position. Recommending that involvement in non-clinical work, including volunteering to work with non-clinical teams is very important to acquire the necessary experience. Recommending that even with formal business training, physician executives should take advantage of training opportunities that allow application of what they have learned. In other words recommending that both formal training through acquiring an actual business qualification in combination with learning on the job to acquire the exposure to the practical aspects of management training. Focusing on building a pool of non-clinical experience.

According to (Conbere *et al* ., 2010) working out what it is that physicians need to learn to be effective leaders should the first step of any training programme and then, figuring out how to deliver such training should be the next step. They propose that, teaching methods that encourage physicians to be reflective and become more self- aware should be used to deliver training that is needed. Case studies are one good example of such training but one would imagine that coaching on the job would also deliver this kind of training. The belief is that physicians, due to their clinical training, are not really encouraged to be introspective and to understand themselves. Self-awareness and emotional intelligence have been mentioned as traits that need to be cultivated in leaders and have been viewed as particularly lacking amongst physicians due to their culturisation during medical school training.

2.7 SUMMARY

The need for management training amongst Medical Managers and doctors at various levels and various specialties seems to be an international problem. There is consensus on the need for training physicians in management and leadership fields. All work reviewed showed that the traditional training of doctors has almost exclusively focused on the physician as a clinician and not on physicians as managers or leaders within healthcare systems in medical schools all over the world.

Depending on the career path of the clinician, it has been recommended that degrees are more suited for clinicians taking on management as a career choice. Clinicians who seek to augment their day to day clinical practice and small group management within clinical units but remaining mostly in clinical practice, the recommendation has been that short courses would be more suitable. In relation to the South African context, Fonn (2011) expressed a concern of a definite skills shortage in the management of healthcare in South Africa with the problem of poor co-ordination between Government and the institutions of higher learning that offer healthcare leadership and management development training.

Cases of organisational and state medical leadership development initiatives have been shown in a few countries with reports of great success. Emphasis on the adoption of a learning culture by organisations has also been highlighted as a cultivator of increased eagerness to self-development amongst employees. Individual attitudes and initiatives have also been indicated to play a significant role, especially in organisations where a culture of continuous learning is not adopted. An emphasis on the combination of formal learning methods with informal methods has come highly recommended. The formal learning of leadership and business concept, followed by exposure to opportunity to apply learned concepts under guidance, i.e. coaching and mentoring is also broadly recommended. Therefore the method of experiential learning used in medical schools that clinicians are accustomed to, has been recommended widely. A need to help physician managers unlearn some of the attitudes and styles of working learned during years of clinical practice alone, has also been highlighted. The approach of one glove fits all in relation to offering leadership and management training to physicians has been discouraged.

In conclusion, according to the literature review, figuring out what physicians need to learn or unlearn should be the first step to any medical leadership training initiative. This should be followed by working out the best way to deliver such training. Chapter Three will elaborate on the research methodology adopted for the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The study aimed to establish whether training gaps existed in the management training of Medical Managers in KwaZulu-Natal Public hospitals. The literature review clarified what the perceptions are in terms of what Medical Managers do and the required competencies for them to effectively do their work. Armed with this information the next step was to ascertain how KwaZulu-Natal Medical Managers rate the relevance of each of these tasks, rate their own performance of these tasks and where gaps are identified, record what their preferred method required training would be. The goal was to quantify the training needs in order to make accurate and quantifiable recommendations for future attempts at addressing the training needs faced by the KwaZulu-Natal Medical Managers.

3.2 RESEARCH METHODOLOGY

Research methodologies are classified as qualitative, quantitative or a combination of both. They have been defined as follows:

3.2.1 Quantitative Research

This type of research aims to systematically measure and scientifically assess certain social phenomena, (Nardi, 2003). The intention is to make quantifiable conclusion on the matters of research interest. Little emphasis is placed on the natural environment that units of analysis exist and their interactions with certain variables of interest. The advantages of this approach is that it

is cost effective, less labour intensive and is easier to compare with other previous similar studies using similar questions (Nardi, 2003).

3.2.2 Qualitative Research

According to Babbie and Mouton (2001), qualitative research is research that looks into reasons people (respondents) have for giving the responses that they do. They refer to the terms as 'contextualistic' and 'holistic' as descriptive of the nature of qualitative research. Thus such a study is attempts to understand the environment which is subject of the research. The aim was to provide in-depth descriptions of the findings. It has been said that a quantitative research approach is based on the belief that unless we understand the environment within human behaviour manifests, we cannot really understand it (Wellman and Kruger, 1999).

3.2.3 Triangulation

Triangulation is defined as a research method that combines different types of research approaches with the aim to reduce the short falls of individual research approaches, it is therefore a combination of qualitative and quantitative research to improve the quality and accuracy of the data that is collected (Babbie and Mouton, 2001).

3.3 THE RESEARCH APPROACH ADOPTED

This study used a combination of both quantitative and qualitative methodologies through a questionnaire that combined close ended type questions and a smaller section that was composed of an open-ended question with a limited number of responses. The reason that this was done, was to draw on the strengths of the two methods.

Summarising the difference between qualitative and quantitative research, Babbie and Mouton (2001) defined the differences based on the approach of the setting, aim of the research, research strategy and notion of objectivity (Table 3.1). The differences between a quantitative and qualitative study are elaborated on Table 3.1.

Table 3.1 Qualitative and quantitative Methodologies (BABBIE, E., MOUTON, J.,2001: 273.The practice of social research. South African Edition.

	Quantitative Study	Qualitative Study
Approach to the setting	Controlled setting Selected samples	Natural settings Whole context
Aim of research	Quantitative descriptions Explanation and prediction	Thick description Interpretative understanding
Research Strategy	Hypothetico-deductive Generalising (nomothetic)	Inductive Contextualising(idiographic)
Notion of objectivity	Natural science definition: Maximum control over extraneous factors	Close as possible to subjects/trust-worthiness and credibility

In a study done on medical specialists in the Netherlands concerning their training needs it was found that the questionnaire was the preferred instrument. This type of approach was suitable due to its minimum intrusion on the work of clinicians as the data tool is self-administered by the respondent at a time most suitable for the respondent. This is especially important as doctors are known for their very busy schedules (Bax *et al* ., 2011).

Some of the studies reviewed internationally that motivated the selection of a predominantly quantitative method for this study based on a self-administered questionnaire as a survey tool were:

- Views of West African surgeons on how well their educational and professional backgrounds may have prepared them for health leadership role(Mahmoud *et al* ., 2010);
- Assessment of Management Education and Training for healthcare providers in the Slovak Republic (Rusnakova *et al* ., 2004) and
- Residents' Perceived Physician-Manager Educational Needs: A National Survey of Psychiatry Residents (Sockalingam *et al* ., 2008).

The above studies all set out to establish training needs amongst physicians at various levels of seniority.

3.4 POPULATION

The study was conducted on the Medical Managers of all public hospitals in KwaZulu-Natal. The hospitals are distributed fairly evenly over a geographic area of around 92,100 square kilometers (Department of Health, 2011a). There is one Medical Manager per public hospital and during the period of the of the study there were 39 district hospitals, 14 regional hospitals,10 TB hospitals, 6 Psychiatry hospitals and 2 Chronic hospitals. There are therefore 71 hospitals in the province of KwaZulu-Natal altogether meaning that there are 71 Medical Manager posts representing the whole population of Medical Managers within public hospitals in this province

3.5 RESEARCH APPROACH

An approach combining both quantitative and qualitative research approaches was adopted utilising an e-mailed, self-administered questionnaire that had one open ended question supplemented by close ended questions. This approach was selected because it allowed the respondents to respond at a time that suited them the most with the privacy to reflect on each question without any pressure. The 37 close ended questions made quantifying responses easier as only ratings were requested. The single open-ended question at the end of the questionnaire allowed the respondents to contribute with some limitation a list of up to ten other training needs not covered by the questionnaire, providing further insight into the training needs problem.

The assured anonymity of respondents that was built into the data collecting and processing process increased the likelihood of the truthfulness of respondent responses as the questions were personal to an extent, i.e. personal competency perceptions. An exclusively qualitative approach would not suit the needs of this study as the great amount of detail was not necessary as this study was aimed at primarily quantifying the extent to which the perceived problem existed. Therefore a combination method was selected. Due to time and resource constraints, this method was also the most suitable. The use of e-mails is cost-effective in relation to sending and

receiving data to and from the vast distances at which respondents are located. The use of e-mails might be viewed as compromising the anonymity of respondents. The names and responses of respondents were kept anonymous, where respondents were only allocated numbers for an example Respondent 1, Respondent 2, Respondent 3 and so forth. The names of respondents and their hospitals were not revealed.

The sample of respondents consisted of individuals who were highly literate, who were within the same profession and who engaged in the same or similar tasks. The interest of the research was to establish individual views on the tasks that they all performed. Therefore the tool could be easily standardised as required of questionnaires without much of a challenge (Babbie and Moutton, 2001). This research approach allowed for a level of flexibility in the sense that both close-ended and open-ended questions could be posed to ascertain various facts about certain areas of interest of this study. The last section of the questionnaire allowed respondents to list their ten areas of training need that were not specifically covered by the questionnaire, this gave respondents room for inclusion of any additional training needs not otherwise covered by the research tool.

3.6 POPULATION and SAMPLE

As mentioned above, 54 Medical Manager positions were filled at the time that this study was done; this represented the whole population of medical managers at the time. The assumption that this study made was that each hospital had a Medical Manager post as implied by the listing of senior hospital management teams on the KwaZulu-Natal Department of health Website. Out of the total of 71 provincial hospitals, it was found that the posts of Medical Manager at 17 hospitals were vacant. This reduced the potential respondent size from 71 to 54.

3.7 DATA COLLECTION

The data was collected using a pre-existing training needs analysis questionnaire designed specifically for training needs analysis of healthcare workers across all disciplines. The

questionnaire was e-mailed to all current Medical Managers inviting them to participate in the study. Respondents were requested to either e-mail or fax their responses back to the research office.

3.8 ETHICAL ISSUES

Before the study commenced, the necessary gatekeeper's consent (Appendix 5) was secured from the KwaZulu-Natal Department of Health's Health Research & Knowledge Management Sub-component. The adapted questionnaire, informed consent form and the gatekeeper's consent were then sent to all Medical Managers. In the e-mail it was made clear that the survey was strictly for academic purposes. The informed consent also made it clear that the participation in the survey was voluntary and respondent contributions in the survey would be kept anonymous. Although e-mail may be seen as compromising anonymity, the identity of respondents was assured and no third party had access to the data. Coding of respondents was done for the purposes of data analysis to maintain anonymity.

3.9 QUESTIONNAIRE DESIGN

Initially a questionnaire was to be designed for this research however it was decided to use an existing, tested and more suitable questionnaire instead.

3.9.1 The Development of the Original Hennessy-Hicks Training Needs Analysis Questionnaire

The research tool was developed by Dr. Deborah Hennessy and Professor Carolyn Hicks of Birmingham University through a process of thematic data analysis of relevant literature, focus groups and semi-structured interviews. Themes of task were established from these interactions with subsequent formulation of specific tasks under each theme.

A pilot questionnaire was formulated and tested on health professionals from all disciplines, responses formulated were statistically analysed and further refinements were done which resulted in the tool being in its current form. The questionnaire was originally used with great success in first world countries. It has also been adapted for utilisation in the third world countries with great success (Hennessy *et al* ., 2006). The permission to use the tool for the purposes of this research was secured via communication with one of the authors through e-mail (Appendix1). The original questionnaire was composed of five subsections under which various tasks on the questionnaire were grouped. The subsections were:

- research/audit;
- communication/teamwork;
- clinical tasks;
- administration and
- Management/supervisory tasks.

The original questionnaire had a list of 30 tasks that respondents had to rate along a 7 point scale. The tasks are rated on four different ratings along this scale. The first rating was on the relevance of the task to the respondents work environment, on a scale of 1 to 7. The score of 1 being equivalent to the least possible relevance and 7 being most relevant.The second rating was on the respondent's perceived ability to perform that task, also on a scale of 1 to 7. The score of 1 being the poorest perceived performance, whilst 7 represented the best possible perceived performance. The third rating was on the respondents' perceived likelihood of receiving required training through changes in work circumstances alone, i.e. other people, resources and so forth. This training method is rated as a training method preferred to address the need for training on a scale of 1 to 7 for the particular task. The score of 1 being the least preferred method and the rating of 7, being the most preferred method of training preferred to address the need. The forth rating was on the respondents' perceived likelihood of receiving the required training through attending formal training session like workshops and courses. This is also rated on 1 to 7 scales. The score of 1 being the lowest possible perception that formal training will attend to that training need and the score of 7 expressing the strongest belief that formal training will address the training needs for that task.

The original questionnaire was designed such that certain carefully guided changes can be made to the questionnaire without affecting the validity of the questionnaire as a training analysis tool. The questionnaire was modified for the purposes of this study to improve its relevance to the context of this study. Two modifications were made. The first modification was on the original 30 items, where the actual tasks were not changed but only rephrased to fit the context. The second change made to the original questionnaire was the complete change of task number 22 and complete omission of tasks number18 and 24 (Table 3.1). Based on the literature review done, this task was perceived not to be relevant and a replacement with a more relevant task was made. Tasks that were relevant to clinical work were therefore omitted as they were not relevant to this study. The third change that was made was the addition of 9 additional tasks relevant to Medical Managers. These additional tasks were generated based on the literature reviewed and a focus group composed of ten Medical Managers verified the relevance of the tasks. In total the tool had a list of 37 tasks to be rated on the four criteria already mentioned i.e. task relevance, task performance levels, task training based on work environment changes and task training based on formal training through courses, workshops and other formal learning programmes. The data collected through the Hennessy and Hicks questionnaire was meant to enable the clarification of individual and group training needs in the following ways:

- Identify training needs at the individual, team, group or organisational levels;
- Inform educational and training packages at the individual, group or Organisational levels;
- Evaluate educational outcomes;
- Customise training to meet local needs;
- Aid priority setting and
- Inform policy development.

The tool was selected because of its previous extensive use within healthcare in both first and third world countries with significant success (Hennessy *et al* ., 2006). The tool's ability to identify training needs at group level as well as address preferred training needs in the same setting makes it ideal for helping answer all the questions that this study set out to answer. There was a demographic profile cover page to the questionnaire that was left unchanged. The original

questionnaire had separated the task rating of training needs from that of Training preference such that the questionnaire had two sections. There was a section at the end of the questionnaire that was open-ended and allowed the respondents to list training needs not covered by the questionnaire. The adapted tool combined the two rating sections into one so that each task is rated on all four ratings at once. This was done to shorten the duration of time it took for respondents to go through the questionnaire. Separating the two sections made the questionnaire look too long (Appendix 6 and7). Table 3.2 shows the process of adapting the tasks on the original questionnaire for this study. The left column shows the original tasks as they appeared in the original questionnaire and the right column shows the adapted version of the questionnaire. The final questionnaire had only the items in the right column.

3.9.2 The Adaptation of the Questionnaire

Table 3.2 summarises the process of adaptation of the original training needs analysis questionnaire for the purposes of this study.

Table 3.2 The Adaptation of the Questionnaire

Hennessy-Hicks Training Needs Analysis Questionnaire Adaptation	
Standard TNA Questionnaire	***Adaptation for Assessing the Training needs of Medical Managers***
1. Establishing a relationship with patients	1. Establishing a relationship with clinicians
2.Doing paperwork and/or routine data Inputting	2. Doing paperwork and/or routine data inputting
3. Critically evaluating published research	3. Critically evaluating published clinical and healthcare management research
4. Appraising your own performance	4. Appraising your clinicians' performance
5. Getting on with your colleagues	5. Getting on with your colleagues (within management)
6. Interpreting your own research findings	6. Interpreting your own and your clinician's research findings in clinical audits
7. Applying research results to your own practice	7. Applying research results to your hospital environment
8. Communicating with patients face-to-face	8. Communicating with clinicians face-to-face
9. Identifying viable research topics	9. Identifying viable research topics in your field of work
10. Treating patients	10.Managing clinicians(as clinicians and employees

11. Introducing new ideas at work	11.Introducing new ideas at work
12.Accessing relevant literature for your clinical work	12. Accessing relevant literature for your clinical and managerial work.
13. Providing feedback to colleagues	13.Providing feedback to colleagues
14. Giving information to patients and/or carers	14.Giving information to clinicians
15. Statistically analyzing your own research Data	15.Statistically analyzing your own research Data
16. Showing colleagues and/or students how to do things	16. Showing colleagues and/or clinicians how to do things
17. Planning and organizing an individual patient's care	17. Planning and organizing an individual clinician's training plan.
18. Evaluating patients' psychological and social needs	18. Omitted
19. Organizing your own time effectively	19.Organizing your own time effectively
20. Using technical equipment, including Computers	20.Using technical equipment, including Computers
21. Writing reports of your research studies	21. Writing reports of your research studies, component quarterly and annual performance reports, official correspondence and other relevant documents.
22. Undertaking health promotion activities	22.Managing allied healthcare workers effectively [CHANGED]
23. Making do with limited resources	23.Making do with limited resources
24.Assessing patients' clinical needs	24.OMITTED
25.Collecting and collating relevant research	25. Collecting and collating relevant research
26. Designing a research study	26.Designing a research study
27. Working as a member of a team	27.Working as a member of a team
28. Accessing research resources e.g. time, money, information, equipment	28.Accessing research resources e.g. time, money, information, equipment
29. Undertaking administrative activities	29.Undertaking administrative activities
30 Personally coping with change in the health Service	30.Coping with change in public healthcare Services plans and strategies
	31.Facilitating a multidisciplinary approach to patient care
	32.Recruitment and retention of staff
	33.Conforming to and understanding relevant legislative framework governing your areas of work e.g. NHA,PFMA etc.
	34.Translation of broader departmental plans into your components operational plans
	35.Motivation of staff
	36.Stress management
	37.How to chair meetings effectively

	38.Clinical policy formulation
	39 Conducting clinical audits and effecting necessary change

The left column in Table 3.2 lists the tasks as they appear in the original questionnaire. The column on the right shows how the questions were either changed omitted or left the same. This was the only part of the questionnaire that was changed. The demographic profiling was left unchanged and the last section allowing the respondents to list ten areas of training need not covered by the task list was also left unchanged.

3.10 PRE-TESTING AND VALIDATION

The process of maintaining the validity of the tool was guided by the original authors of the research tool. The steps that had to be followed were that "up to 25% of the basic items of the original questionnaire can be changed or omitted and a further 10 added, without compromising informed by literature review and taken through a validity process where the list of the additional task plus the original tasks was e-mailed to a smaller group hospital. This was followed up by telephonic interviews for managers who had not responded. All reviews received were positive and affirmed the relevance of all added tasks and pre-existing ones. The tasks were then added onto the tool. This resulted in the final adapted questionnaire (Appendix7).

A pilot study is a process that is normally done before the actual study to help address any potential problems before the actual study is undertaken. For this study a pilot study was conducted where the objectives of the study and the questionnaire were sent to a group of ten hospital managers i.e. Chief Executive Officers (supervisors of Medical Managers) within the province KwaZulu-Natal. It was confirmed that the research questions in the questionnaire were relevant to the objectives and that there were no double barrelled questions and nor were there any leading or vague ones. This confirmed the face validity of the study. The research was conducted ethically and respondents were free to answer on their own free will without influence from the research process. The entire process was conducted scientifically and objectively thus ensuring that data analysed was not manipulated in any way and the findings presented a true

reflection of the research. In the light of this, there is every confidence that should the study be replicated by others, very similar results will be obtained. This indicates that reliability is achieved. Hennessy and Hicks did a similar adaptation of the training needs analysis questionnaire in a study done on nurses in Indonesia, which is a Third World setting like South Africa. They followed the same steps as done in this study and validity of the tool was maintained (Hennessy *et al* ., 2006).

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3.11 ANALYSIS OF THE DATA

The authors of the original questionnaire recommended that results are interpreted manually for both the identification of training need and the preferred method of training. The data was analysed in two phases. A simple subtraction method for training need analysis was used. The rating of performance for each task was subtracted from the relevance rating of that task for each and every respondent. The identification of training need for the task was based on the difference between the two on a scale of 1 to 7. The differences of each task for all respondents were added and an average training need for the group for each task calculated. For an example if the average difference is high, say rating of 7, and the average perceived level of performance is 2. This implies that a very important task is on average not being performed well; therefore a training need exists with a rating of 5. The assessment of training preferences for the group was done using average group rating for each method for each task. Excel software was used to process the data into graphical illustrations.

An analysis of the greatest training needs for the groups were determined by the task with the highest average difference between task relevance and performance for the group. This exercise was done for all tasks. If the difference in score is reversed where the rating on relevance is low and the rating on performance is high. This signifies a low training priority i.e. a very unimportant task is being performed very well. Each of the tasks was assessed in this way for training need analysis. All tasks that respondents indicated as requiring a high priority in terms of training were highlighted and assessed for the preferred training method. The training method with a higher average score in the group for the tasks with the highest training needs was

regarded as the training need of choice as expressed by the average of respondent scores. The results of the survey, for the purposes of this research were interpreted for the group not for individuals. The identities of the respondents have been kept anonymous in the presentation of the data through allocation of numbers to all respondents. Neither hospital names nor names of respondents' are mentioned.

3.12 FIELDWORK

Following the securing of necessary permissions, contact details of all Medical Managers were sourced from the KwaZulu-Natal Department of Health's website as advised by the Health Knowledge Management Sub-component. This was a significant challenge as some of the Medical Managers' contact information was outdated. For each of the hospitals where no current Medical Manager details were available, a telephone call was made to update contact information.

The contact information was either in a form of an e-mail address or mobile phone number and sometimes both. An official invitation to participate in the survey was e-mailed to all Medical Managers whose e-mail addresses were available. Medical Managers without e-mail addresses were either called telephonically or an electronic cellular message was sent to their mobile phones extending an invitation. Some of the managers where neither e-mail addresses nor mobile phone contact details were available or were incorrect were contacted via hospital landlines. On securing all possible contact information, the questionnaire, informed consent form and a copy of the Department of Health's gatekeeper consent were e-mailed to all potential respondents. The gatekeeper's consent was received a month before the study was due to be concluded; this presented a very tight deadline.

Reminders were sent one week after the original e-mailing, due to the limited time available to conclude the study. The original request to target respondents had to be resent numerous times in order to ensure submission. Only two of the Medical Managers officially declined to participate, stating reasons. One cited their disagreement with the study approach therefore lack of enthusiasm to participate, the second Medical Manager seemed much stressed in the Medical

Manager position and expressed the intention to resign in the very near future and refused to be associated with the study.

3.13 SUMMARY

The selection of a research method that combined quantitative and qualitative elements to ascertain the training needs of Medical Managers was used. This resulted in the study drawing on the strengths of both methods as highlighted above. This helped cover aspects of training needs not covered by the task list on the questionnaire and allowed respondents to give further insights into the problem of training needs in this group. A sample of 30 out of a population of 54 was used and that as a result of the research having 30 respondents, the recommendations can be generalised as highlighted by (Sekeran, 2003).

CHAPTER FOUR

PRESENTATION OF RESULTS

4.1 INTRODUCTION

The original projected number of respondents wants estimated at 71 in line with the number of public hospitals within the province of KwaZulu-Natal. Contact information for all hospital was sourced from the KwaZulu-Natal Department of Health's website. Most of the Medical Managers direct contact information was readily available. A number of the hospital declared the status of Medical Manager posts as vacant. Ultimately of the original 71 hospital, 17 had vacant posts which therefore reduced the number of prospective respondents from 71 to 54 potential respondents. Two prospective respondents of the 54 officially declined to participate. The number of respondents who responded totaled 30; this reflected a 55.5% response rate.

4.2 THE RESPONDENTS' DEMOGRAPHIC PROFILE

The demographic profiles of respondents who were all Medical Managers follow:

Table 4.1 Racial Distribution of Respondents

Race	**Percentage of respondents**
Asian	23%
Black African	64%
White	13%

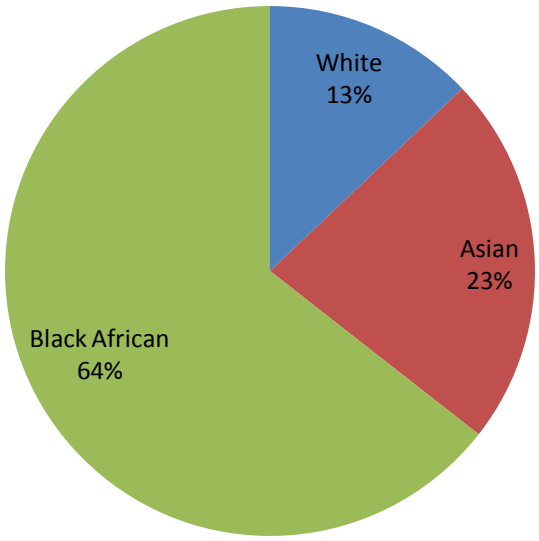

Figure 4.1 Racial Distribution

It can be seen that the racial breakdown of Medical Managers is such that it reflects the level of transformation in South African society. A 64 percent of Medical Managers within KwaZulu-Natal public hospital were Black African, 23 percent Asian and 13 percent White. This is aligned with the South African government initiatives to empower previously disadvantaged South Africans through employment equity initiatives.

Table 4.2 Years in Post of Respondents

Years in Post	Percentage of Respondents
0 - 5 years	67 %
6 - 10 years	10 %
More than 10 years	23%

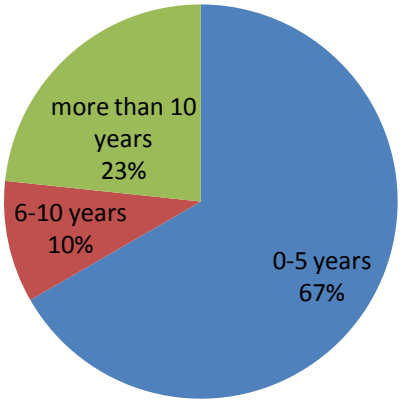

Figure 4.2 Years in Post

The respondents with more than ten years of service as Medical Managers closely resemble the responses to the previous profile where 13% were white. Given South Africa post 1994 it is thus not surprising to see that 67% of the Medical Managers have less than five years of experience. This compares with the 64% of Black respondents in Figure 4.1. This finding could also be indicative of poor retention of Medical Managers into the posts beyond 5 and 10 years. Therefore resulting in higher number of newer Medical Managers

Table 4.3 Qualifications of Respondents

Qualification	Percentage of Respondents
MBChB Only	53.3 %
MBChB plus Diploma	13.3 %
MBChB plus other degree(s)	33.3 %

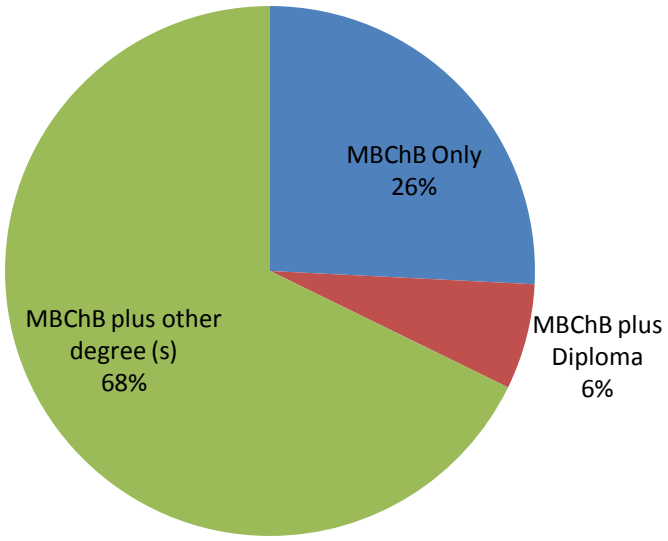

Figure 4.3 Qualifications of Medical Managers

Qualifications were either relevant or irrelevant to management education. These ranged from a public health management degree such as Master of Public Health (MPH) and general management degrees such as the MBA to diplomas in project management and others. Other qualifications were in further education within clinical practice such as qualifications as physicians in Family medicine as well as certain medical diplomas in various fields of Medicine. These qualifications excluded studies being currently undertaken and not yet completed although one respondent mentioned being in a process of completing their studies in an MPH programme. Medical Managers with business degrees constituted 13 percent of the group. The Master of Public Health programme was included in this figure. Respondents with business diplomas constituted 16 percent of the group.

Table 4.4 The Age Distribution of Respondents

Age	Percentage of Respondents
20 – 30 years	Nil
31-40 years	37%
40- 50 years	30%

More than 50 years	33.3%

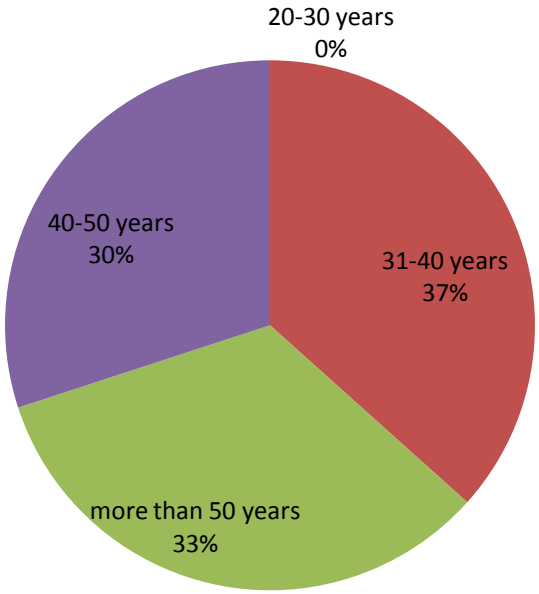

Figure 4.4 Age Distribution of Respondents

One can note a balanced age distribution which reflects positively on succession planning, assuming that individuals are being groomed for such responsibilities. Contrary to what was found in the literature on management in early career doctors, there were no Medical Managers within the 20 to 30 year range.

Table 4.5 The Gender Distribution of Respondent Medical Managers

Gender	Percentage of Respondents
Female	23%
Male	77%

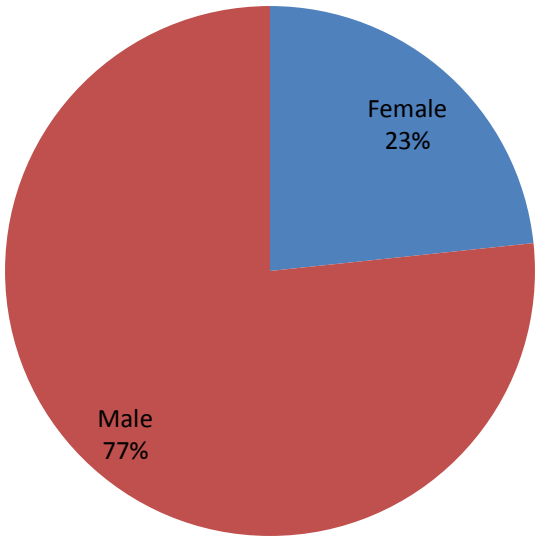

Figure 4.5 The Gender Distribution of Respondents

The gender distribution of respondents heavily skewed toward male gender with 77 percent of Medical Managers being male. This is despite the South African Government's efforts of promoting gender equity and empowerment of the previously disadvantaged, however the racial distribution showed significant success in this regard.

4.3 A TRAINING NEEDS ANALYSIS

The questionnaire audited 37 tasks relevant to day to day Medical Manager operations on a seven point scale (Appendix 7). The tasks were allocated numbers as reflected on the questionnaire for ease of presentation of data. The questionnaire has all tasks numbered and these were the numbers used to identify the tasks on all tables and graphic illustrations. The analysis of average task relevance, task performance rating and the training need scores for each task for the whole group were calculated and the findings summarised (Figure 4.6). The detailed data on training need per task is also available (Appendix 8).

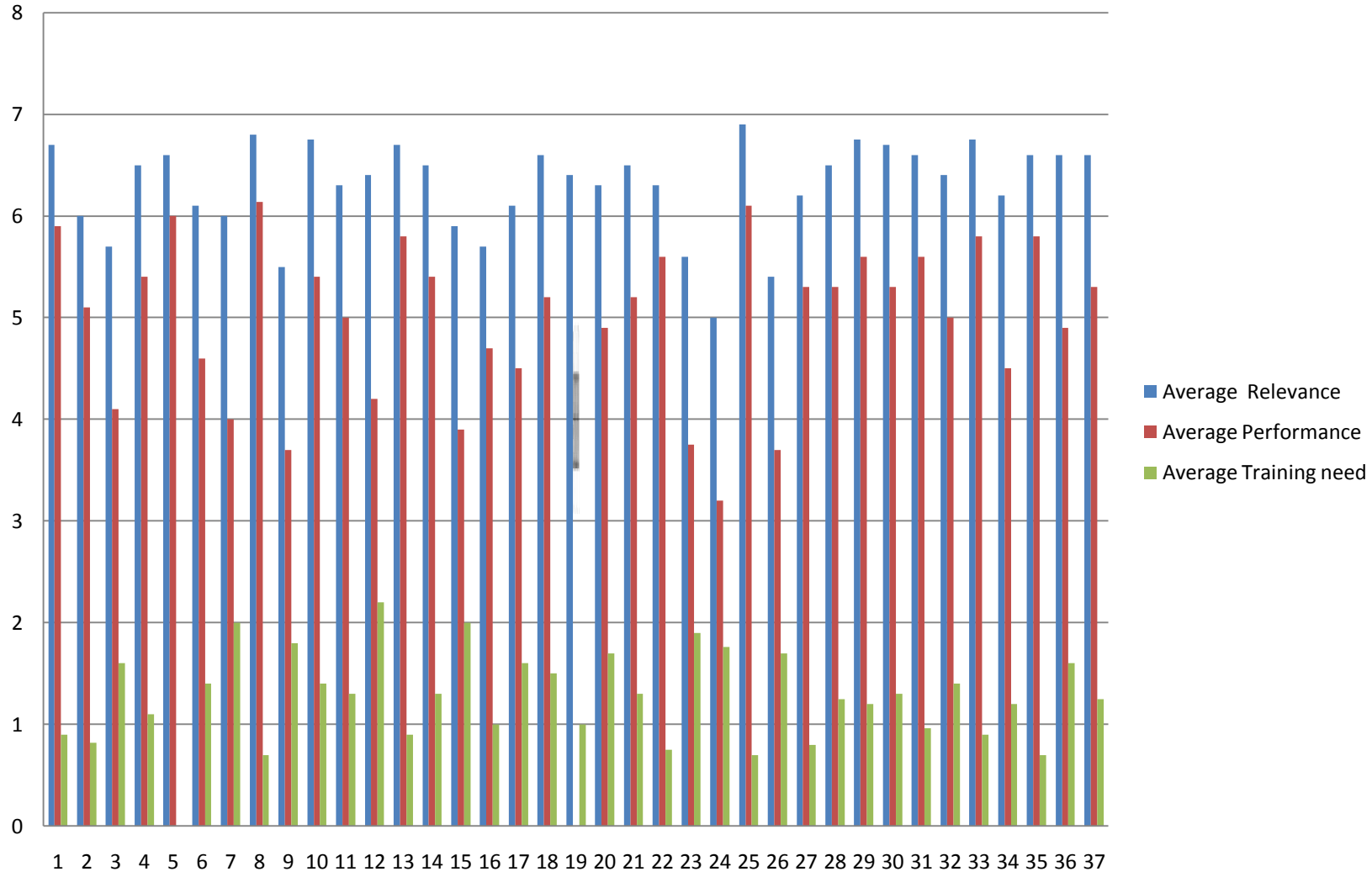

Figure 4.6 Average task relevance, task performance and training need per task for the whole Group

4.3.1 The Calculation of Training Need

All tasks received a relevance rating of 5.0 and above. A majority of the tasks had a rating of above 6.0.The training need was calculated by subtracting performance rating from relevance rating. For an example task number 7 (Table 4.6) was rated 6.0 on average for relevance and 4.0 on average for performance. The calculation of training need was calculated as follows:

Relevance rating – Performance rating= Training need therefore in the task 7 example the calculation would be: 6 – 4 = 2 thus being a rating of 2 on a scale of 1 to 7. Reflecting a low training need on a task rated as fairly important on average.

4.3.2 Training Need Comparisons between tasks

The highest average training need score was 2.2 for task number 12. On a scale of 1 to 7, the training needs seem to be generally low overall. The top twelve rated tasks for training needs were marked "►" (Appendix 9). These were tasks with a training need rating of above 1.5. The top twelve tasks were as follows:

- Task 3: Critically evaluating published clinical and healthcare management research;
- Task 7: Applying research results to your hospital environment;
- Task 9: Identifying viable research topics in your field of work;
- Task 12: Accessing relevant literature for your clinical and managerial work;
- Task 15: Statistically analysing your own research data;
- Task 17: Planning and organising an individual clinician's training plan;
- Task 18: Organising your own time effectively;
- Task 20: Writing reports of your research studies, component quarterly and annual performance reports, official correspondence and other relevant documents;
- Task 23: Collecting and collating relevant research;
- Task 24: Designing a research study;
- Task 26: Accessing research resources e.g. time, money, information, equipment and
- Task 36: Clinical policy formulation.

The analysis shows a trend of training needs in writing skills, researching skills, accessing and utilisation of relevant data for purposes of improving day to day operations. Clinical policy formulation, planning and organising individual clinician development plans as well as skills in own time management. Although the training need ratings were not very strong overall, these were the tasks that received the highest rating in training need. Tasks that received the lowest relevance rating, that is, a rating below the rating of 6.0 were:

- Task 3: Critically evaluating published clinical and healthcare management research;
- Task 9 :Identifying viable research topics in your field of work;
- Task 15: Statistically analysing your own research data;
- Task 16: Showing colleagues and/or clinicians how to do things;
- Task 23: Collecting and collating relevant research and
- Task 24: Designing a research study.

Tasks under research have been rated low on relevance but high on training need. This finding is surprising as the expectation was that tasks higher on relevance would have also been the ones reflecting a higher need for training. However the tasks that were rated high on training needs, tended to rate low for performance ratings (Appendix 9). This means that although a task might have been rated low on relevance and low on performance, respondents still perceived it as an important skill to master and rated it high on training need.

4.4 TRAINING METHOD PREFERENCES

All 37 tasks were rated against the two training methods. Training on the job or informal training and training through formal training like courses and workshops. Average rating per tasks was calculated (Appendix 10) and Figure 4.7 shows the rating of each task under the two categories. Noticeable, is the almost equal rating of both on the job training and formal training for each and every task. The formal training rating was rated higher on 23 of the 37 tasks but the difference in rating was negligible. This probably indicates an almost equal preference for both methods and possibly a need for a combination training method might be implied by the findings. Figure 4.6 shows the predominance of formal training preferences amongst respondents.

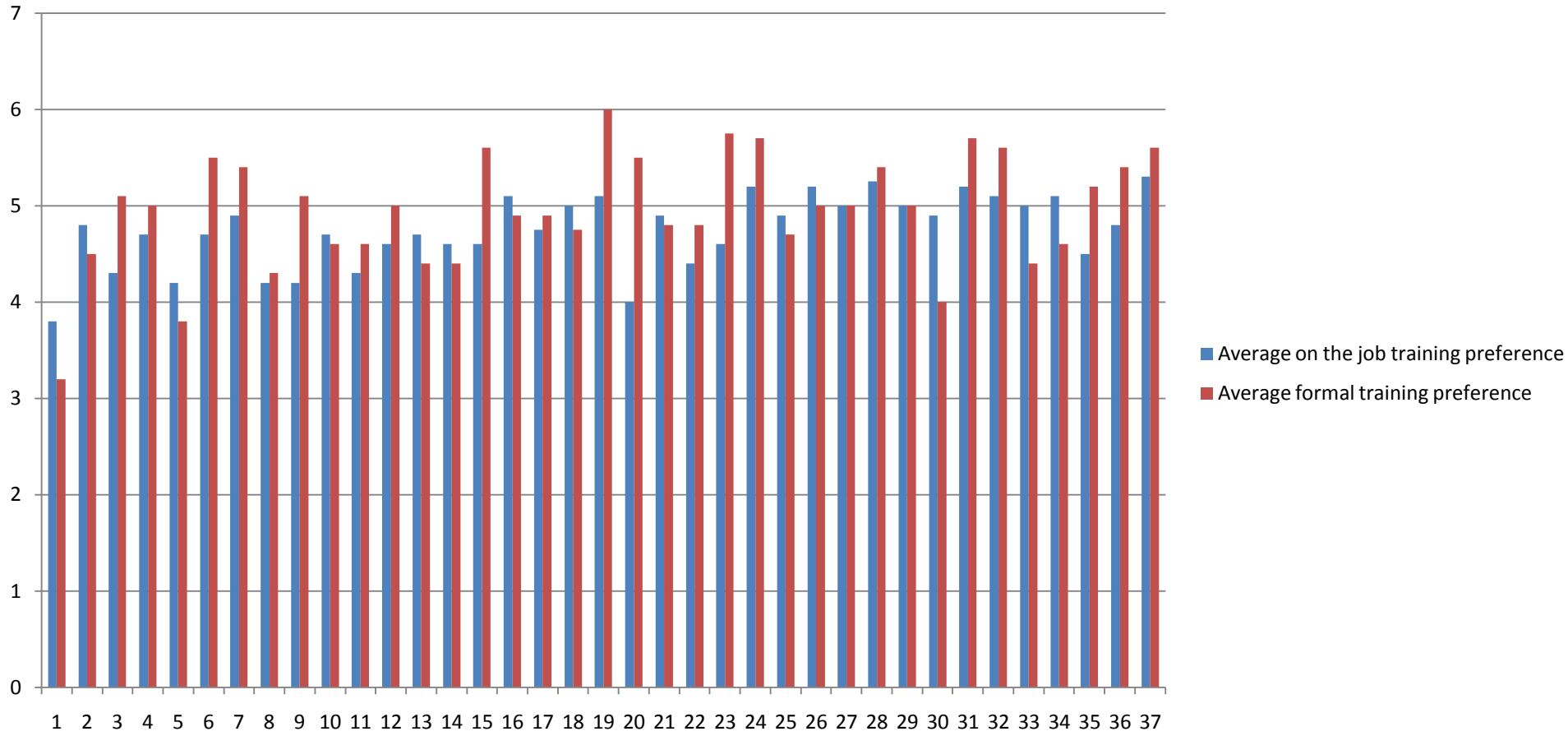

Figure 4.7 Medical Manager Training Preferences per Task as Demonstrated by Group Averages

4.5 ADDITIONAL TRAINING NEEDS AS LISTED BY RESPONDENTS

The second part of the questionnaire was more open-ended. Respondents were requested to list up to ten training areas that they personally felt were important but not covered by the questionnaire. Table 4.7 below shows the list of areas of training need mentioned and the number of times each area was mentioned.

Table 4.7 Additional Training Needs as Specified by Respondents

Area of Training Need	Number of times mentioned by respondents
Lean Management	3
Financial Management	13
Human Resource Management, staff recruitment and retention.	6
Public Health Management	10
IT and using technical equipment	4
Project Management	3
Strategic Management	3
Clinical Governance/Clinical audits	10
Epidemiology	2
Research	19
Relevant Legislative Framework	1
Team Building	2
Relationship Management with Executive	1
Quality assurance and improvement	3
Workplace diversity planning	1
Labour Relations	4
Procurement management	3
Managing Clinicians that are clinically more senior than self	1
Managing Heads of Clinical units	1
Administrative duties and business Management	1

Communication	1
Performance management	1
Data Management	1
Policy formulation	3
Writing reports and official correspondence	1
Chairing meetings	1
Stress Management	1
Mentorship	1
Time Management	1
Change Management	3
Responding to patient's complaints	1
Ethics	2
Medical Law	1
Risk Management	1

The percentage of respondents that listed the following areas as additional training required:

Research (63 percent);

Financial management (43 percent);

Public Health management (33 percent) and

Clinical governance and Audit (33 percent).

These areas were the top four listed and reflect a significant need for training in research skills overall.

It was noted that respondents who managed specialist level hospitals expressed a unique training need that is worth highlighting. This was a need to acquire training in the management of physicians who are more senior to Medical Managers. These clinicians are more senior in clinical expertise and clinical qualifications. In an environment where Medical Managers need to maintain legitimacy as managers and as clinician managers and leaders, the fact that most Medical Managers only possess a basic qualification as medical doctor (MBChB) becomes a point of weakness. This poses a unique challenge when Medical Managers who are junior in clinical qualifications and expertise supervise the work of clinicians who are specialist and respected experts in their field of clinical practice. Having to challenge specialist level clinicians on their day to day decisions related to clinical practice

that Medical Managers themselves are not qualified to practice, might be viewed as undermining their authority to lead. These particular training areas were highlighted on the list of additional training needs (Table 4.7) as the 'management of clinicians senior to self' and the 'management of Heads of Clinical unit'.

4.6 CONCLUSION

The study set out to establish whether training needs existed amongst Medical Managers in KwaZulu-Natal public hospitals. A pre-existing training needs analysis tool, modified for Medical Managers, was used. The findings show that training needs do exist for these Medical Managers. Most of the tasks assessed were rated very high on relevance by respondents, this reflected positively on the questionnaire's content as a tool. The respondent rating of individual performance levels were also rated fairly high on average. This in turn resulted in a generally low training need rating overall as reflected by the respondent ratings. Chapter five will make conclusions and recommendation on the study's objectives.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

This study set out to investigate management training needs of Medical Managers in public hospitals in KwaZulu-Natal. The objectives were to establish if such training needs existed and if they were found to exist, to establish where the training needs are and the most preferred training method to deliver such training. Literature on this topic was reviewed in Chapter two to ascertain international views on the topic. This chapter looks at what the literature review found and considers the literature findings with the findings of this study. Recommendations are made under each objective.

5.2. THE PRESENCE OR ABSENCE OF MANAGEMENT TRAINING NEEDS AMONGST MEDICAL MANAGERS (Objective 1)

5.2.1 Literature

According to the literature review, the presence of management training gaps amongst Medical Managers was affirmed. Various local and international studies reached the same conclusion. The study done on Canadian psychiatry residents' views on physician manager needs, affirmed gaps in physician manager training (Sockalingam *et al* ., 2008). A South African study that looked at skills gaps in hospital management, at both public and private hospitals, affirmed the presence of training gaps amongst hospital managers (Pillay, 2010). A study on Dutch hospital Medical Managers found that although specialists felt confident about their management skills and knowledge, they felt that a gap existed in their management training, (Bax *et al* ., 2011). These were just a few of the many studies that were reviewed in chapter two that revealed that a gap in the management training of physicians existed. These gaps existed from undergraduate level to specialist level clinical training.

5.2.2 Fieldwork

The findings of this study showed the presence of management training needs in almost all the tasks that were audited. The relevance of all tasks on the questionnaire was affirmed by the above 5 rating of all tasks by respondents on a scale of 1 to 7 on relevance. Meaning that, the management training needs exist amongst Medical Managers in Public Hospital of KwaZulu-Natal, even though the need was generally rated low on average. The average training need rating for the group was 2.2 and below on a scale of 1 to 7. The tasks audited were categorised along the following categories:

- research/audit;
- communication/teamwork;
- administration and
- management/supervisory tasks.

5.2.3 Conclusion

Based on the findings in both the literature review and this research's findings, the presence of training needs is affirmed.

5.2.4 Recommendation

The recommendation is that a similar analysis is made on the presence of such training needs, in the view of Medical Manager Supervisors. This exercise could possibly further affirm the level of training need in line with higher levels of training needs amongst Medical managers expressed internationally.

5.3 THE ACTUAL TRAINING GAPS OF MEDICAL MANAGERS (Objective 2)

5.3.1 Literature

Literature that was reviewed on where the training gaps of Medical Managers is, generally focused on management and leadership training gaps. The Medical Leadership Alliance Model looked at a common competency framework for health care managers. Areas identified were communication and relationship building, leadership, professionalism, knowledge of the healthcare system and business knowledge and skills (Stefl, 2008). A study

that was done in Slovak Republic on training needs of healthcare managers found that gaps existed in management and leadership training amongst managers. Gaps were identified in areas of change management, operational management, Human resource management and financial management. There was a general consensus in all the work that was reviewed that management training needs exist in one form or another amongst Medical Managers internationally. The presence of management training gaps in both healthcare management skills and people leadership skills.

5.3.2 Fieldwork

The findings of this study indicated that the tasks that showed the highest training need, with average training needs rating of between 1.5 and 2.2 on a scale of 1 to 7 were:

- Task 3:Critically evaluating published clinical and healthcare management research;
- Task 7: Applying research results to your hospital environment;
- Task 9: Identifying viable research topics in your field of work;
- Task 12: Accessing relevant literature for your clinical and managerial work;
- Task 15: Statistically analysing your own research data;
- Task 17: Planning and organising an individual clinician's training plan;
- Task 18: Organising your own time effectively;
- Task 20: Writing reports of your research studies, component quarterly and annual performance reports, official correspondence and other relevant documents;
- Task 23: Collecting and collating relevant research;
- Task 24: Designing a research study;
- Task 26: Accessing research resources e.g. time, money, information, equipment and
- Task 36: Clinical policy formulation.

5.3.3 Conclusion

Tasks under the research/audit and administration categories, illustrated the highest training need.

5.3.4 Recommendations

The list of tasks used in the research tool was not an exhaustive list of what Medical Managers do but focused only on core tasks that Medical Managers do. Although the training

need findings of this study present an informative picture of areas of training need, a more comprehensive study might portray a more complete picture of the training needs of this group of Medical Managers. The open-ended question revealed some very interesting findings like that highlighted by Medical Managers who, as phrased by one of the respondents, supervise 'clinicians more senior to self'. It's recommended that a more qualitative study taking a closer look at the training needs of Medical Managers in context, might bring very interesting training needs to light.

5.4 THE TRAINING METHODOLOGY OF CHOICE (Objective 3)

5.4.1 Literature

There were varying views on the approach to management training in the literature review in Chapter 2. The general trend was towards a combination of formal course based training to learn theory on management concepts combined with experiential learning to put learned material to practice; in line with learning cultures adopted in most medical school programmes internationally. One such recommendation was made where it was said that 70 percent of training should be based on on-the job learning, 20 percent based on drawing from others around the work environment and 10 percent from formal learning through courses, workshop and others (Duberman, 2011).

Another study looked at the process of the formation of the Medical leadership programme in Columbia Children's hospital in the United States. The programme went through stages of assessing training gaps, carefully designing specific programmes aimed at specifically addressing those gaps identified (McAlearney *et al* ., 2005). A recommendation that healthcare organisations and departments invest in developing organisation-specific Medical leadership development programmes aligned with organisational leadership needs was also made. Management training initiatives of clinicians seem to be moving towards the incorporation of management sciences at undergraduate level as seen in the case of medical schools in the United States (Butcher, 2011). In the context of the United Kingdom a similar move was seen through the establishment of the Clinical Advisory Programme. This programme was said to recruit both junior and senior doctors for an apprenticeship with senior healthcare leaders, learning through experiential exposure (Coltart *et al* ., 2012), that is in line with the views advocating on-the job learning.

The general view is that the training needs of Medical Managers should first be carefully assessed. The design of the training programme should also be carefully thought through. The design of the training programme has to take the culture of learning that physicians are used to in medical school into account. Training needs to combine both the formal phase of learning of management concepts with an opportunity for application of learned concepts is recommended. The importance of mentorship and coaching by more senior colleagues is also recommended by most of the studies on training Medical Manager reviewed in chapter 2. Other forms of informal learning have been highlighted, like the consumption of general business publications that other non-healthcare managers are reading to keep up to date with current thinking on management practices (Blattner, 2010).

5.4.2 Fieldwork

The findings of this study following the analysis of average training preferences of all the tasks audited, showed an overall higher preference for formal training. Where 38 percent of the tasks revealed an average preference for on the job training and 62 percent of the task showed a preference for formal course based learning. Most of the individual respondent preferences showed a split with a fairly even split between formal training and on the job training.

5.4.3 Conclusion

Both the literature and this study's finding are in agreement. A method combining both formal and informal learning methods is preferred and recommended to teach Medical Managers management concepts. In line with how local and international medical school programmes are structured, where clinical theory is taught formally through lectures and tutorials followed by theoretical application through patient bedside teaching and practical clinical skill practice.

5.4.4 Recommendations

In line with the findings of both the literature review and this study, a teaching method that combines both formal and informal teaching methods is recommended to teach Medical Managers management concepts. A method that Medical Managers as clinician managers are already use to, in line with their learning culture in Medical School.

5.5 SUGGESTIONS FOR FURTHER RESEARCH

Possible weaknesses of this study have been highlighted. These were the limited task inventory on the questionnaire, the subjectivity of the ratings given by respondents, the lack of in depth understating of the context within which the training needs exist through the study's adoption of a research approach that was predominantly quantitative. The recommendation for further research within a better resourced background would be as follows:

- The adoption of a qualitative method in order to best understand the context of the problem and receive unrestricted input from the respondents and
- Research that reduced the problem of subjectivity of respondents, through the inclusion of Medical Manager supervisors (Chief Executive Officers) or subordinates to assess performance rating and training need of Medical Managers and therefore increasing objectivity of the study's findings .

As previously mentioned, the list of tasks that were used in the questionnaire was not an exhaustive list of tasks that Medical Managers do. Research that would look at a more comprehensive list of tasks that Medical Managers do and take the tasks through a similar rating process could conclude on a more wholistic training needs analysis. The significant subjectivity of the ratings in this study was perceived as a possible point of weakness of the analysis. A more objective rating of the tasks may yield more accurate results. The recommendation that research that looked at more objective opinions of Medical Managers' supervisors i.e. Hospital Chief Executive Officers is being made. This approach could result in a more accurate training needs analysis.

A better resourced study could also look at the more comprehensive list of tasks and take the analysis from Provincial to National level and thus covering all the Provinces. Ultimately such research would have the ability to make recommendations for Medical Manager Training initiatives for the whole population of South African Public Hospital Medical Managers. This approach could possibly contribute to Medical Manager Training initiatives nationally.

5.6 SUMMARY

The study's objective was to establish if there were gaps in the management training of Medical Managers. The literature reviewed confirmed the presence of management training gaps at all levels of physician training both at undergraduate and post graduate level. The findings of the study were in line with the international trends and views. Although the training need was found to be generally low as competency to perform tasks was rated quite high overall by all respondents. The greatest training needs focused on tasks under the research and audit category and administration. Although this study's findings may have been significantly influenced by the subjectivity of the ratings, insight into training needs by individuals may vary depending on the individuals' attitude towards learning and their organisational culture around learning and continuous performance appraisal. The presence of a continuous performance appraisal system to highlight training needs would make a difference in individual manager training needs awareness. Therefore a study that might look at the same tasks rating in a more objective approach might give a more accurate results and therefore more accurate recommendations.

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APPENDICES

Appendix 1

DEBORAH HENNESSY deb.hennessy@btinternet.com

Aug 17

Dear Velile Ngidi

We would be delighted to give you permission to use the Hennessy-Hicks Questionnaire in your MBA Study of medical managers in Kwa-Zulu public hospitals. The tool should provide you with very interesting answers.

We have used the tool for medical managers with different disciplinary backgrounds in Public Hospitals in one area of Victoria, New South Wales, Australia. Although unpublished the results were fascinating. The results were delivered to the participants in a workshop and focus group and their observations were even more illuminating.

We also used the tool for a study of public health managers in the Orange Free State in about 1998. These results were presented in a poster demonstration at an International Council of Nursing Conference in London in about 1999. The results were also used to strengthen a Course in Health Care Management. So I know that the tool could be very helpful in your study.

We will be interested to hear about your results in due course.
In the meantime we wish you well in your studies.

Regards

Deborah Hennessy PhD.
(NB: The above letter has been copied from my own personal e-mail)

Appendix 2

Advertisement of KwaZulu-Natal Department of Health Manager Posts

CLINICAL MANAGER GRADE 1 (MEDICAL MANAGER)
0

applicants

55

No. Views

POST: CLINICAL MANAGER GRADE 1 (MEDICAL MANAGER)
CENTRE: CATHERINE BOOTH HOSPITAL
REFERENCE NO.: CBH 28/2012
NUMBER POSTS: 01
REMUNERATION PACKAGE
SALARY: R744 309.00 p.a

ADDITIONAL BENEFITS
Commuted• overtime
13th cheque•
Medical aid (optional)•
Rural allowance (18%• of basic salary)

REQUIREMENTS FOR THE POST
An appropriate• qualification in the appropriate Health Sciences (MBChB or equivalent) PLUS
• Current registration with the HPCSA as a Medical Practitioner PLUS
A• minimum of three (03) years appropriate experience after registration with the HPCSA as Medical Practitioner.
Non South African citizen applicants need to• have a valid work permit in conformance with HR circular 49/2008 obtainable from any government department
Computer literacy•

RECOMMENDATIONS
A• relevant management qualification and/or experience will be an added advantage
Valid unendorsed drivers' licence•

KNOWLEDGE, SKILLS, TRAINING, AND COMPETENCIES REQUIRED
Knowledge of and skills in human• resource management, strategic management, financial management and operations management in the hospital and clinic environment
Knowledge of the relevant• Acts, Policies and Regulations
Knowledge of EPMDS/ Performance• Management
Sound knowledge of the District and National Health System•

• Knowledge of budget cycle, strategic planning and operational planning
• Ability to manage and optimize the use of financial and human resources
• Ability to provide an understanding of responsibility and authority when delegating as well as assigning tasks/functions to employees, with the necessary guidance and support
Good communication, supervisory, leadership,• decision-making, team-building and motivation skills, computer literacy
• Ability to work under stress, and the possession of time management and conflict resolution skills
Sound clinical knowledge and experience, including the• ability to diagnose and manage common medical problems
Ability to conduct• Caesarean Sections and/or administer anaesthesia

KEY PERFORMANCE AREAS
Co-ordinate and manage medical and allied medical services (including• pharmacy, therapists, dietetics, social work, audiology, dental clinic and radiography) at Catherine Booth Hospital and supported clinics
Ensure that• a professional and effective medical service is provided to clients within the available budgetary constraints
Carry out performance management of all• reportees
Maintain discipline and deal with grievances and Labour Relations• issues in terms of the laid down procedures and policies
Development,• implementation, monitoring and evaluation of clinical protocols
Ensure the• monitoring of quality of care and cost effectiveness, e.g. clinical audits and DHIS
Implementation of quality assurance and quality improvement• programmes, as well as strategic planning
Participate in various relevant• committees of the hospital
Conduct and coordinate in-service training for• staff
Maintain clinical, professional and ethical standards at all• times
Ensure the provision of safe, ethical and high quality medical,• surgical and emergency care for all departments
Provide after-hour medical• / administrative services when the need arises or as per roster

CLOSING DATE: 07 NOVEMBER 2012

ENQUIRIES: Mrs. PZ Mbonambi TEL: 035 474 8402

Appendix 3

Table 2.2 Created from: What Doctors Want. LETOURNEAU, B. 2004. What Doctors Want. *Journal of Healthcare Management,* 49**,** 219.

What Doctors Want
• Enthusiastic and technically competent staff
• Low staff turnover
• Mutually respectful relationship between staff, patients and physicians
• A clearly articulated strategic plan that takes into account the professional interests of physicians and their practice
• Solid Communication from leadership to physicians regarding the organization's short and long-tem plans and reasons for their decisions
• Physician's awareness of their role in decision making
• Opportunities for physicians to get involved in a variety of ways
• Leadership advocacy for physicians needs and support for their practice
• Leadership consideration of factors beyond the bottom line
• Improvement efforts that are relevant to physician practices
• Immediate attention paid to issues that are raised by and that affect physicians
• Consistent efforts to communicate or enhance communication systems with physicians
• Processes for receiving physician concerns or feedback and for timely follow up.

Appendix 4

Table 2.10 Summary of top hospital managers' training needs. RUSNAKOVA, V., BACHAROVA, L., BOULTON, G., HLAVACKA, S. & WEST, D. J., JR. 2004. Assessment of management education and training for healthcare providers in the Slovak Republic. *Hospital Topics,* 82**,** 23.

Topics	Total group	Medical professional
Operational management		
Introductory learning programs; basic programs with specific focus	2.80	2.86
Administration and policy formation in patient care	3.27	3.21
Decision making in planning and policy formation	3.40	3.21
Understanding the interaction between the external/internal environment	3.43	3.14
Skills audit to identify operational management competencies	3.48	3.54
Equipment maintenance	2.92	2.64
System design for operational management		
Information technology and using computers	3.63	3.50
Information systems for hospital administration	3.67	3.50
Communication with superiors	3.30	3.07
Current views on operational management	3.50	3.14
Planning for operational management		
Evaluation methods for operational management	3.47	3.36
Strategic planning for hospitals	3.83	3.93
Educational planning for hospitals	3.70	3.79
Quality assurance in healthcare	4.23	4.43
Time management	3.67	3.43
Quality control for operational services in hospitals	4.00	4.00
Financial management		
Introductory learning programs; techniques in financial management	3.03	3.43
Budgeting	3.23	3.50
Costing	3.30	3.64
Methods used in public sector	2.67	3.00
Regulatory and policy frameworks	2.50	2.36
Skills in financial management		
Managing self-sufficiency	3.30	3.50
Credit management	2.93	3.21
Payroll management	3.30	3.57
Income management	3.30	3.57
Taxation management	3.00	3.00
Other information needs		
Accounting principles in healthcare services	2.80	3.07
Information systems in financial management	2.97	3.21
Computerization in financial management	2.90	2.93
Documentation methods	3.00	3.00
Human resource management		
Introductory learning programs; special topics for HRM	3.07	3.14
Staff selection	3.67	3.36
Staff guidance and control	3.77	3.57
Staff appraisal	3.83	3.71
Managing poor performers	3.83	4.00
Staff training and skill development	3.77	3.71
Improving internal communication	3.77	3.64
Job design	3.30	3.07
Managing staff morale and improving job satisfaction[a]	3.67	3.71
Occupational health and safety[a]	3.43	3.29
Management of organization change[a]		
Introductory learning programs; strategic management and planning	3.27	3.71
Organizational change strategies	3.83	3.93
Working with government policies	3.47	3.29
Working with municipal policies	3.67	3.57
Working with new technology	3.72	3.50
Identifying managerial problems in Slovakia	3.67	3.86
Managing change in hospitals		
Implementation of change policies	3.70	4.07
Preparing staff for change and overcoming resistance	3.93	4.36
The role of leadership in change management	3.73	4.36

Notes. Summary is for the total study groups and for managers with medical backgrounds. The values of the average scores are presented. The scales ranged from 1 (minimum) to 5 (maximum).
[a]These are averages.

Appendix 5 KwaZulu-Natal Department of Health Gatekeeper's Consent

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM 120/12
Enquiries : Mr X Xaba
Tel : 033 – 395 2805

Dear Dr V. Ngidi

Subject: Approval of a Research Proposal

1. The research proposal titled **'Training needs of Medical Managers in Public Hospitals in KwaZulu Natal'** was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken in all hospitals.

2. You are requested to take note of the following:
   a. **Make the necessary arrangement with the Medical Managers in hospitals before questionnaires are emailed to them.**
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 27/09/2012

Appendix 6 Original Hennessy-Hicks training needs analysis questionnaire and manual

HENNESSY-HICKS TRAINING NEEDS ANALYSIS QUESTIONNAIRE AND MANUAL

For use at a local level to identify training and development needs

Professor Carolyn Hicks, BA, MA, PhD, PGCE, CPsychol.
School of Health and Population Sciences,
College of Medicine and Dentistry
University of Birmingham, UK

Dr Deborah Hennessy BA, PhD, RN, RM, Diploma Public Health Nursing, HV, FRSM
Consultant to World Health Organisation
5 Westfield House,80 Westgate
Chichester United Kingdom, UK

NB: Please note that page numbers are as for the original manual

Questionnaire only, the whole manual is available on:
http://www.who.int/workforcealliance/knowledge/HennessyHicks_trainingneedstool.pdf

HENNESSY-HICKS ASSESSMENT OF TRAINING NEEDS AND APPROACHES TO PERFORMANCE IMPROVEMENT

Before reading the instructions please complete the following*:

Job title:

Gender:

Age:

Number of years in post:

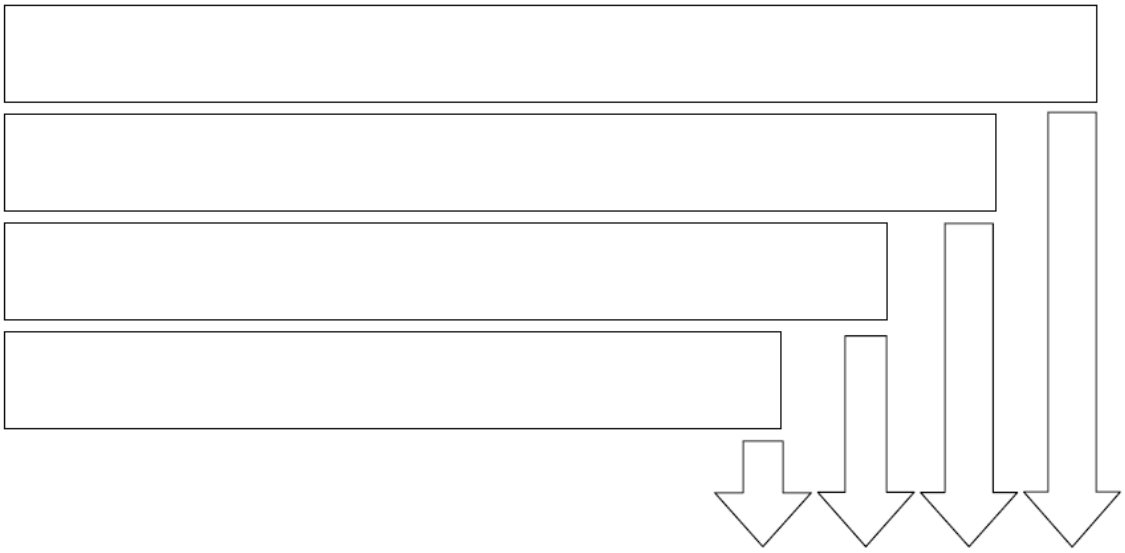
*[*Please note that this section can be adapted to collect any information considered to be relevant to the study, for example, educational qualifications, professional qualifications, previous training etc could be included here]*

INSTRUCTIONS FOR COMPLETION:

This questionnaire comprises four sections that are to do with your training needs. Please answer all the questions as honestly as possible to enable us to compile a complete picture of your training requirements. Each section is prefaced by instructions for completion. Please read and follow these carefully.

SECTION 1: Training needs

In order to perform your job effectively you need relevant skills. You will see listed below a range of skilled activities many of which you undertake in performing your job. Look at each of these activities and then rate each one by writing the appropriate number in the box. The first rating (A) is concerned with how important the activity is to the successful performance or your job; the second rating (B) is concerned with how well you currently perform that activity. However, in order to perform well at work, you also require suitable work circumstances (eg other people's approach, compatible work practices, lack of practical constraints etc). In other words, your working environment should allow you to exercise your skills appropriately. Therefore, the second two ratings (C and D) are concerned with the scope for improving performance either through training alone or through changes in your work situation.



	A	B	C	D
1. Establishing a relationship with patients				
. Doing paperwork and/or routine data inputting				
3. Critically evaluating published research				
4. Appraising your own performance				
5. Getting on with your colleagues				
6. Interpreting your own research findings				
7. Applying research results to your own practice				
8. Communicating with patients face-to-face				
9. Identifying viable research topics				
10. Treating patients				
11. Introducing new ideas at work				
12.Accessing relevant literature for your clinical work				
13. Providing feedback to colleagues				
14. Giving information to patients and/or carers				
15. Statistically analyzing your own research data				
16. Showing colleagues and/or students how to do things				

18

17. Planning and organizing an individual patient's care				
18. Evaluating patients' psychological and social needs				
19. Organizing your own time effectively				
20. Using technical equipment, including computers				
21. Writing reports of your research studies				
22. Undertaking health promotion activities				
23. Making do with limited resources				
24. Assessing patients' clinical needs				
25. Collecting and collating relevant research information				
26. Designing a research study				
27. Working as a member of a team				
28. Accessing research resources (e.g. time, money, information, equipment)				
29. Undertaking administrative activities				
30 personally coping with change in the health service				

SECTION 2: Specific training needs

Please specify the areas of your job in which you would like to receive further training or instruction. List these in order of importance:

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Appendix 7 Adapted questionnaire – Hennessy Hicks questionnaire

RESEARCH QUESTIONNAIRE

Before reading the instructions please complete the following:

Job title:

Gender:

Age:

Race:

Number of years in post:

Qualifications:

Instructions for completion:

This questionnaire comprises of two sections that are to do with your training needs. Please answer all the questions as honestly as possible to enable us to compile a complete picture of your training requirements. Each section is prefaced by instructions for completion. Please read and follow these carefully.

SECTION 1: Training needs

In order to perform your job effectively you need relevant skills. You will see listed below a range of skilled activities many of which you undertake in performing your job. Look at each of these activities and then rate each one by writing the appropriate number in the box. The first rating (A) is concerned with how important the activity is to the successful performance of your job; the second rating (B) is concerned with how well you currently perform that activity. However, in order to perform well at work, you also require suitable work circumstances (e.g. other people's approach, compatible work practices, lack of practical constraints etc). In other words, your working environment should allow you to exercise your skills appropriately. Therefore, the second two ratings (C and D) are concerned with the scope for improving performance either through training alone or through changes in your work situation.

A: How important is this activity to the successful performance of your job?
Rating of 1-7- not at all important = 1; very important = 7

B: How well do you consider that you currently perform this activity?

Rating of 1- 7 - not well = 1; very well = 7

C: How much do you feel that the training needs of this activity can be addressed by change in your work situation alone?

Rating of 1 -7, totally disagree = 1; totally agree=7

D: How much you feel that the training needs for this activity can be addressed by training alone?

Rating of 1 -7, totally disagree = 1; totally agree=7

Task	A	B	C	D
1. Establishing a relationship with clinicians.				
2. Doing paperwork and/or routine data inputting				
3. Critically evaluating published clinical and healthcare management research				
4. Appraising your clinicians' performance				
5. Getting on with your colleagues (within management)				
6. Interpreting your own and your clinician's research findings in clinical audits				
7. Applying research results to your hospital environment				
8. Communicating with clinicians face-to-face				
9. Identifying viable research topics in your field of work				
10. Managing clinicians(as clinicians and as employees)				
11. Introducing new ideas at work				
12. Accessing relevant literature for your clinical and managerial work.				
13. Providing feedback to colleagues				
14. Giving information to clinicians				
15. Statistically analyzing your own research data				
16. Showing colleagues and/or clinicians how to do things				
17. Planning and organizing an individual clinician's training plan.				
18. Organizing your own time effectively				
19. Using technical equipment, including computers				
20. Writing reports of your research studies, component quarterly and annual performance reports, official correspondence and other relevant documents.				
21. Managing allied healthcare workers effectively				
22. Making do with limited resources				
23. Collecting and collating relevant research				
24. Designing a research study				
25. Working as a member of a team				
26. Accessing research resources e.g. time, money, information, equipment				

27. Undertaking administrative activities				
28. Coping with change in public healthcare Services plans and strategies				
29. Facilitating a multidisciplinary approach to patient care				
30. Recruitment and retention of staff				
31. Conforming to and understanding relevant legislative framework governing your areas of work e.g. NHA,PFMA etc				
32. Translation of broader departmental plans into your components operational plans				
33. Motivation of staff				
34. Stress management				
35. How to chair meetings effectively				
36. Clinical policy formulation				
37. Conducting clinical audits and effecting necessary change				

SECTION 2: Specific training needs

Please specify the areas of your job in which you would like to receive further training or instruction. List these in order of importance:

1.

2.

3.

4.

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Appendix 8 Average training needs analysis data

Task	Average Relevance	Average Performance	Average Training need
1.	6.7	5.9	0.8
2.	6.0	5.1	0.9
3.	5.7	4.1	1.5
4.	6.5	5.4	1.1
5.	6.6	6.0	0,8
6.	6.1	4.6	1.5
7.	6.0	4.0	2.2
8.	6.8	6.14	0.6
9.	5.5	3.7	1.8
10.	6.75	5.4	1.4
11.	6.3	5.0	1.3
12.	6.4.	4.2	2.2
13.	6.7	5.8	0.9
14.	6.5	5.4	1.2
15.	5.9	3.9	2.2
16.	5.7	4.7	1.0
17.	6.1	4.5	1.6
18.	6.6	5.2	1.5
19.	6.4	5.3	1.0
20.	6.3	4.9	1.6
21.	6.5	5.2	1.3
22.	6.3	5.6	0.9
23.	5.6	3.75	1.9
24.	5.0	3.2	1.8
25.	6.9	6.1	0.7
26.	5.4	3.7	1.9
27.	6.2	5.3	0.8
28.	6.5	5.3	1.2
29.	6.75	5.6	1.2
30.	6.7	5.3	1.3
31.	6.6	5.6	0.96
32.	6.4	5.0	1.4
33.	6.75	5.8	0.9
34.	6.2	4.5	1.2
35.	6.6	5.8	0.7
36.	6.6	4.9	1.6
37.	6.6	5.3	1.25
Total	**157.8**	**185.19**	**43.01**
Average	**4.3**	**5.0**	**1.16**

Appendix 9 Average training preference method data

Task	Aver. on the job Training preference	Average course based training preference	Preferred method
1.	3.9	3.3	On the job
2.	5.0	4.7	On the job
3.	4.3	5.1	Formal
4.	4.7	5.0	Formal
5.	4.4	4.0	On the job
6.	4.7	4.8	Formal
7.	4.9	5.3	Formal
8.	4.2	4.2	Both
9.	4.5	5.1	Formal
10.	4.7	4.6	On the job
11.	4.4	4.7	Formal
12.	4.7	4.9	Formal
13.	4.7	4.4	On the job
14.	4.6	4.4	On the job
15.	4.6	5.5	Formal
16.	5.1	4.9	On the job
17.	4.8	4.9	Formal
18.	5.0	4.8	On the job
19.	5.1	6.0	Formal
20.	4.1	5.5	Formal
21.	5.0	4.9	On the job
22.	4.5	4.8	Formal
23.	4.6	5.7	Formal
24.	5.2	5.6	Formal
25.	4.9	4.8	On the job
26.	5.3	5.1	On the job
27.	5.0	5.0	Both
28.	5.2	5.4	Formal
29.	5	5	Both
30.	5.0	4.2	On the job
31.	5.4	5.8	Formal
32.	5.1	5.6	Formal
33.	6.75	5.8	On the job
34.	6.2	4.5	On the job
35.	6.6	5.8	On the job
36.	6.6	4.9	On the job
37.	6.6	5.3	On the job
38.			
			3both
Average	**6.2**	**6.1**	17 on the job/17 Formal

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

18 September 2012

Dr Velile Ngidi 943486204
Graduate School of Business and Leadership
Westville Campus

Dear Dr Ngidi

Protocol reference number: HSS/0924/012M
Project title: Training Needs of Medical Managers in Public Hospitals in KwaZulu-Natal.

EXPEDITED APPROVAL

I wish to inform you that your application has been granted Full Approval through an expedited review process.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Professor Steven Collings (Chair)

/pm

cc Supervisor: Alec Bozas
cc Academic Leader: Dr S Bodhanya
cc School Admin: Mrs Wendy Clark

Professor S Collings (Chair)
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